CARE1ST

Nursing Facilities Reference Guide

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PURPOSE

Care1st created this document to serve as a reference for Nursing Facility providers.

VERIFYING MEMBER ELIGIBILITY

Providers may register and verify eligibility using the portal https://online.care1st.com/ca/provider_login.

Eligibility may also be verified by contacting Care1st Member Services at 855-905-3825.

Access To the Web Portal

Contracted providers have access to the web portal. For non-contracted providers, there is access through the use of a user name and password. Please contact the Provider Network Operations department at 323-889-6638 x3388.

DETERMINING RESPONSIBLE PARTY FOR AUTHORIZATION AND PAYMENT

Please contact the Care1st MLTSS Department at 855-622-2755 for questions about authorization and payment responsibilities.

SUBMITTING LONG TERM CARE PRIOR AUTHORIZATION REQUESTS TO CARE1ST

Long Term Care is a continuous admission, covered under Medi-Cal eligibility, at a Nursing Facility or Subacute Facility exceeding the month of admission and the entire following month.

Care1st has two types of Long Term Care authorization forms (see Appendix):

1. Prior Authorization Form for Care Services in a NF
2. Authorization Form for Medi-Cal Long Term Care.

For Los Angeles, complete the appropriate authorization form and submit to Care1st MLTSS via FAX: 844-200-0121. For San Diego, complete the appropriate authorization form and submit to Care1st MLTSS via FAX: 855-303-2232.

Authorization requests must be submitted within 24 hours of admission to the NF or within 5 business days of new eligibility assignment to Care1st Health Plan. Care1st will review the authorization request to certify the patient meets Medi-Cal criteria for Long Term Care Services.

- Care1st will provide a response to authorization requests within five business days.
- Initial authorizations for service and equipment approvals will have an effective period of up to 3 months, depending on care service type. Reauthorizations will typically have an effective period of up to 6 months.
- Authorizations for Medi-Cal long term care, if screened and determined to meet criteria, would typically be issued for a period of 6 months (exceptions based on medical review may deem a longer or shorter duration) after the initial period.

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SUBMITTING INITIAL LONG TERM CARE PRIOR AUTHORIZATION REQUESTS TO CARE1ST

The Care1st Authorization Form for Medi-Cal Long Term Care (LTC TAR) form along with the following information are required when requesting an initial approval (FAX: 844-200-0121 for Los Angeles or 855-303-2232 for San Diego):

1. Face sheet
2. MDS
3. STATE TAR
4. PASARR - Preadmission Screening Resident Review
5. DPOA (if any)

TAR DATA AND EXISTING AUTHORIZATIONS

Care1st will receive TAR information from the State open for Medi-Cal Long Term Care NF residents as part of the historical utilization data. Care1st will honor all existing authorizations from the State automatically for 3 months if an existing TAR from the state is provided and a long term authorization is coordinated.

AUTHORIZATION PROCESSES FOR SHORT TERM SKILLED CARE

Short Term Skilled Care are time-limited admissions to a nursing facility or subacute facility until the completion of a treatment plan, for rehabilitation or continuation of medical acute care services.

- For short term skilled care, please contact the assigned IPA or Care1st Inpatient Department 323.889.6638 x6127/ x6128. Skilled authorization requests will be approved based on CMS and Medi-Cal guidelines.

Medi-Cal Long Term Care:

All members' authorizations and payments will come from Plan.

Medicare Short Term Skilled Care and Medi-Cal Short Term Skilled Care:

Authorization and payment are dependent upon where the risk lies.

- Shared Risk IPA – IPA provides authorization for all services; Provider to bill Plan for facility charges.
- Full Risk IPA – IPA provides authorization for all services; Provider to bill Full Risk Hospital partner for facility charges.

Medi-Cal Long Term Care with Medicare Part B

All members' authorizations and payments will come from Care1st Medi-Cal Long Term Care residents are not assigned to IPAs and care is not delegated to an IPA.

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AUTHORIZATIONS FOR ANCILLARY SERVICES

Some ancillary services require prior authorization. See attached form entitled "Prior Authorization Form for Care Services in a NF".

If Medicare Part A NF care is delegated to the IPA, when the patient qualifies for Medi-Cal Long Term Care level of care, then Care1st becomes responsible for authorization and payment of Medi-Cal Long Term Care services, if the Medi-Cal is also assigned to Care1st. Please contact the Care1st MLTSS Department at 855-622-2755 for questions about authorization and payment responsibilities.

PAYMENT DISPUTES

If there is a dispute between the IPA and the Health Plan for responsibility of payment, Care 1st is responsible for resolving disputes between the IPA and the health plan for responsibility of payment.

For both Medicare and Medi-Cal, the dispute must be resolved within 45 days after notification of the dispute. Care1st will issue a written determination stating the pertinent facts and explaining the reasons for the determination within forty-five (45) working days after the date of receipt of the dispute. Please review and advise as to whether this language is sufficient.

TRAINING

Care1st staff is available to provide orientations and trainings on authorization procedures to all contracted facilities. Please contact the Care1st Provider Network Operations Department at: 323-889-6638 x3388 (Los Angeles) or 888-272-4913 (San Diego).

CLAIMS

Claim Submission

1. A facility may submit claims as frequently as desired.
2. Timeframes for claims submission:
    a. Medicare claims must be submitted within 1 calendar year after date of service
    b. MediCal claims must be submitted within six months following the months in which services were rendered. Payment reduction may apply if claims are not received within the six-month billing period. Claims submitted beyond the six-months billing period maybe paid the full allowed amount if documentations supporting the reason for delay are submitted. Claims that require supporting documents will need to be submitted in paper form.
        i. Payment Reductions – claims that do not have
            1. Pay at 75 percent (%) of the allowed amount if claim does not meet the requirements as noted in the delay reasons and if claim is submitted in 7th to 9th month after month of service
            2. Pay at 50 percent (%) of the allowed amount if claim does not meet the requirements as noted in the delay reasons and if claim is submitted in 10th-12th month after month of service.

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ii. Over-One-Year Claims:

1. Care1st will review all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, administrative errors in determining beneficiary's eligibility and circumstances beyond the provider's control. Reversals of decisions on appealed Treatment Authorization Requests (TARs) will be handled as Provider Appeals. Claims submitted over one year must include copy of the beneficiary's proof of eligibility with Care1st and copy of the original County Letter of Authorization form (Medi-Cal MC-180 form) signed by an official of the county.

iii. Delay Reasons:

Delay Reason	Document to be submitted	Timeframe for submission
1. Proof of eligibility unknown or unavailable	Proof of eligibility with Care1st such as print-out of Eligibility Verification Transaction from the MediCal web-site or AEVS	Within one year from the month of service
2. Share of Cost changes	Share of Cost Medi-Cal Provider letter	Within one year from the month of service
3. TAR approval days or changes on the service levels (i.e. authorization approved by the IPA when Care1st responsibility to pay)	Proof of authorization approval from the IPA	Within one year from the month of service
4. Delay by DHCS in certifying providers	Proof of DHCS certification showing date certified	Within one year from the month of service
5. Third party processing delay (Medicare/Other Health Coverage)	Evidence of Benefit or Remittance Advice from Medicare/Other Health Coverage showing payment or denial	Claims must be received by Medicare or Other Health Coverage within one year after the month of service and by Care1st Health Plan or IPA (depending on who is responsible for payment) within 60 days of the other health carrier's resolution
6. Delay or error in the certification or determination of Medi-Cal eligibility	Proof of eligibility with Care1st such as the MediCal Eligibility Verification transaction	Within one year from the month of service
7. Theft, sabotage	Document justifying the delay reason	Within one year from the month of service

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8. Natural disaster	Letter on provider letterhead describing the circumstances and the date of occurrence. The letter must be signed by the provider or provider's designee	Within one year

iv. Claims that are Over-One-Year claims must be submitted to the following address:

Care1st Health Plan
Mail Stop: CL006 (Over-One-Year Claims)
601 Potrero Grande Dr.
Monterey Park, CA 91755

3. Additional documentation is not required from the NF in order to pay a claim as long as all services billed have been previously authorized and all required billing codes (i.e. RUG, accommodation, revenue) are submitted.
4. Claim must be submitted using form UB-04. Below are information that are required in addition to provider, patient, and other applicable fields:
   a. Bill type: 21X
   b. Statement Dates: dates of service being billed
   c. SOC: use value code fields
      - Paper Claim:
        - Field 39a with code "23", enter SOC amount for covered services in the Amount field
        - Field 40a with code "66", enter SOC amount for non-covered services in the Amount Field
      - Electronic (837I:5010):
        - Loop 2300 AMT01, qualifier "F5" for SOC amount for covered services
        - Loop 2300 AMT01, qualifier "A8" for SOC amount for non-covered services
   d. Enter appropriate revenue code on Field 42
   e. Enter revenue code description on Field 43
   f. Enter one of the following on Field 44 (HCPCS/Rates/HIPPS CODE) of UB-04
   g. Enter Accommodation days or the number of days of care by revenue code on Field 46 (Serv Units)
   h. Enter Total charges on Field 47. Total charges should reflect the MediCal or contracted rates multiply by the quantity.
   i. Enter Estimated Amount Due on Field 55. This is the difference between the Total Charges and other deductions such as SOC.
   j. Enter authorization number on UB-04 field 63 (Authorization Code)
   k. Enter Accommodation code on Field 39, with value code 24. Accommodation code can be entered in cents format in the corresponding amount field.
      - Paper claim example: Accommodation code "01", enter as ".01"
      - Electronic (837I:5010) – Loop 2300 NTE01, qualifier "UPI" and with text entered as follows "Accommodation

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XX" (XX being the code such as 01, 03, etc.)

5. Billing Codes:
   a. **Medicare:**
      - For standard inpatient nursing facility, skilled nursing services, days 1-100 within a benefit period, use revenue code 0022 (UB-04 field 42) with corresponding HIPPS/RUG codes (UB-04 field 44). Benefit period shall reset to the max of 100 days after the member has had at least sixty (60) consecutive days lapse without either an acute inpatient admission and/or post-acute nursing facility days.
      - If contracted reimbursement rates are based on different Skilled Nursing levels, use the following revenue. Accommodation codes are not required for Medicare claims.

SNF Level	Revenue Code
1	191
2	192
3	193
4	194
5	199

   b. **Medi-Cal:**

Long Term Care Accommodation Codes Acronyms:

- DD - Developmentally Disabled
- DD-CN - Developmentally Disabled/Continuous Nursing
- DD-H - Developmentally Disabled/Habilitative
- DD-N - Developmentally Disabled/Nursing
- DP - Distinct Part
- NF - Nursing Facility
- NF A - Nursing Facility Level A
- NF B - Nursing Facility Level B

NF-B Adult Subacute

Description	Revenue Code	Accommodation Code
Hospital DP/NF-B – Ventilator Dependent	199	71
Hospital DP/NF-B – Non-ventilator Dependent	191-194	72
Free-standing NF-B – Ventilator Dependent	199	75
Free-standing NF-B – Non-ventilator Dependent	191-194	76

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NF-B Pediatric Subacute

Description	Revenue Code	Accommodation Code
Hospital DP/NF-B – Supplemental Rehabilitation Therapy Services	191-194	83
Hospital DP/NF-B – Ventilator Weaning Services	199	84
Hospital DP/NF-B – Ventilator Dependent	199	85
Hospital DP/NF-B – Non-ventilator Dependent	191-194	86
Free-standing NF-B – Ventilator Dependent	199	91
Free-standing NF-B – Non-ventilator Dependent	191-194	92
Free-standing DP/NF-B –Supplemental Rehabilitation Therapy Services	191-194	97
Free-standing DP/NF-B – Ventilator Weaning Services	199	98

Long Term Non-skilled Care (Custodial)

Description	Revenue Code	Accommodation Code
NF-B Regular	160	01
NF-B Rural Swing Bed Program	160	04
NF-B Special Treatment Program-Mentally Disordered	169	11
NF-A Regular	160	21
Rehabilitation Program-Mentally Disordered	169	31

Bed Hold (Adult) – Maximum of 7 days per hospitalization
Revenue Code: 185

Description	Accommodation Code
Hospital DP/NF-B – Ventilator Dependent	73
Hospital DP/NF-B – Non-ventilator Dependent	74
Free-standing NF-B – Ventilator Dependent	77
Free-standing NF-B – Non-ventilator Dependent	78

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Bed Hold (Pediatrics) – Maximum of 7 days per hospitalization
Revenue Code: 185

Description	Accommodation Code
Hospital DP/NF-B – Ventilator Dependent	87
Hospital DP/NF-B – Non-ventilator Dependent	88
Free-standing NF-B – Ventilator Dependent	93
Free-standing NF-B – Non-ventilator Dependent	94

Leave of Absence (Adult) – Maximum 18 days per calendar year
Revenue Code: 180

NF-B Adult Subacute

Description	Accommodation Code
Hospital DP/NF-B – Ventilator Dependent	79
Hospital DP/NF-B – Non-ventilator Dependent	80
Free-standing NF-B – Ventilator Dependent	81
Free-standing NF-B – Non-ventilator Dependent	82

Leave of Absence (Pediatric) – Maximum 18 days per calendar year
Revenue Code: 180

Description	Accommodation Code
Hospital DP/NF-B – Ventilator Dependent	89
Hospital DP/NF-B – Non-ventilator Dependent	90
Free-standing NF-B – Ventilator Dependent	95
Free-standing NF-B – Non-ventilator Dependent	96

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Leave of Absence Long Term Non-skilled Care (Custodial) - Maximum 18 days per calendar year
Revenue Code: 180

Description	Accommodation Code (Non-DD)	Accommodation Code (DD)
NF-B Regular	02	03
NF-B Rural Swing Bed Program	05	N/A
NF-B Special Treatment Program-Mentally Disordered	12	N/A
NF-A Regular	22	23
Rehabilitation Program-Mentally Disordered	32	N/A

c. **Cal Medi-Connect**

- Medicare Part A – follow billing guide as noted in Medicare billing codes if claim is Care1st responsibility to pay
- Medi-Cal portion of benefits such as skilled nursing days 101+, Long Term Care, Bed Hold and Leave of Absence Days- follow billing guide as noted in the Medi-Cal billing

6. Claims can be submitted electronically through the following clearing houses:

EMDEON	OFFICE ALLY
PAYER ID: 57115	PAYER ID: C1SCA
(877) 363-3666	(866) 575-4120
www.emdeon.com	www.officeally.com

Please contact one of these clearing houses to enroll for this service.

7. Paper claims can be submitted to the following address:

Care1st Health Plan
Mail Stop: CL001
601 Potrero Grande Dr.
Monterey Park, CA 91755

Date of Receipt

The date of receipt for paper claims is the date Care1st receives the claim, as indicated by its date stamp on the claim. If the claim should come in electronically, the date the claim is received from the claims clearing house will serve as the date of receipt for the claim.

Claim Reimbursement Timelines

Care1st will make every effort to pay claims as required by the regulations.

1. Medicare

a. Clean claim from non-contract providers will be paid within 30 calendar days from receipt of claim

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b. Unclean claim from non-contract providers and all other claims will be paid or denied within 60 calendar days from receipt of claim
c. CMS requires that 95% of clean claims are paid within 30 calendar days and 95% of all other claims are paid or denied within 60 calendar days.

2. Medi-Cal

a. Claim must be processed (paid, denied or contested) within 30 calendar days from receipt of claim.

b. 90% of claims must be paid, denied or contested within 30 calendar days from receipt of claims or 95% within 45 working days.

3. Cal Medi-Connect

Clean claims will be paid within thirty (30) calendar days after receipt. As per DPL 14-002, 90% of all clean claims for contracting NF providers within 30 calendar days and 99% within 90 calendar days.

Reimbursement Rates:

1. Care1st will reimburse contracted providers at contractual rates or letter of agreement.
2. Out-of-network or non-contracted providers will be reimbursed at rates not less than the current Medicare fee schedule for services covered under Medicare Part A (skilled services for days 1-100)
3. Sub-Acute Nursing Facility and Long Term Services, leave of absence and bed hold will be paid at 100% of the current facility specific Medi-Cal Subacute Facility and Skilled Nursing Nursing Facility rates schedule as published by DHCS
4. Out-of-network or non-contracted providers will be reimbursed at rates not less than the current Medicare for Part B covered services such as physical, occupational therapies and MediCal rates for those services that are covered under MediCal.
5. Medi-Cal Fee Schedule rate for nursing facility and long term care facility Covered Services includes all supplies, drugs, equipment, and personal hygiene items necessary to provide a designated level of care. These items are included in the Medi-Cal rate unless listed as separately reimbursable in *California Code of Regulations* (CCR), Title 22. All incontinence supplies are included in the facility rates and are not separately reimbursable for dual eligible members.
   Provider shall not bill for these. Care1st will not reimburse Provider for such inclusive services. Inclusive items are as follows:
   - Routine Supplies
   - Non-legend Drugs
   - Incontinence Supplies (except for ICF/DD-N and ICF/DD-H)
   - Personal hygiene items
   - Nursing services
6. The following items are excluded from the Medi-Cal Fee Schedule for nursing facility and long term care facility Covered Services per *California Code of Regulations* (CCR), Title 22 and such items are separately reimbursable (except for sub-acute facilities, see CCR Title 22 for details). Prior authorization from Care1st or its Delegated IPA is required prior to delivery to dual eligible member and prior to payment. Provider will use best efforts to ensure Care1st designated Participating Providers for such items are used and Plan reserves the right to re-direct accordingly.

Excluded, separately reimbursable, items for non-sub acute facilities are as follows:

- Allied health services ordered by the attending physician
- Alternating pressure mattresses/pads with motor
- Atmospheric oxygen concentrators and enrichers and accessories
- Blood, plasma and substitutes
- Dental services
- Durable Medical Equipment as specified in CCR, Title 22, Section 51321(g)
- Insulin
- Intermittent positive pressure breathing equipment

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- Intravenous trays, tubing and blood infusion sets
- Laboratory services
- Legend drugs {Payable only through pharmacy benefit management system}
- Liquid oxygen system
- MacLaren or Pogon Buggy
- Medical Supplies as specified in the *Welfare and Institutions Code* (W&I Code), Section 14105.47
- Nasal Cannula
- Osteogenesis stimulator device
- Oxygen (except emergency)
- Parts and labor for repairs of Durable Medical Equipment if originally separately reimbursable or owned by recipient
- Physician Services
- Portable aspirator
- Portable gas oxygen system and accessories
- Precontoured structures (VASCO-PASS, cut out foam)
- Prescribed prosthetic and orthotic devices for exclusive use of patient
- Reagent testing sets
- Therapeutic air/fluid support systems/beds
- Therapy services that are provided by a licensed therapist, identified in the Minimum Data Set, included in the recipient's plan of care and prescribed by the recipient's physician
- Traction equipment and accessories
- Variable height beds
- X-rays

Electronic Payment:

Care1st partnered with JP Morgan to provide this service. To register for electronic payment:

Contact JP Morgan:
By phone: (866) 474-2250
By email: HCP.support@jpmorgan.com

Share of Cost (SOC)

1. Care1st Health Plan will process claims submitted by nursing facilities consistent with Medi-Cal Share of Cost provisions included in DPL 14-002
2. Care1st will process claims submitted by nursing facilities consistent with Medi-Cal guidelines for SOC.
3. SOC for Non-Covered Services
   As a result of the *Johnson v. Rank*, Medi-Cal beneficiaries, not their providers, can elect to use SOC funds to pay for necessary, non-covered, medical/remedial services, supplies, equipment and drugs prescribed by a physician and part of the care plan authorized by the beneficiary's attending physician. A medical service is considered a non-covered benefit if:
   - The medical service is rendered by a non-Medi-Cal provider; or
   - The medical service falls into the category of services for which an authorization request has to be submitted and approved before Medi-Cal will pay and an auth request is not submitted or is denied because the service is not considered medically necessary.
   - The physician's prescriptions for SOC expenditures must be maintained in the beneficiary's medical record.

As required by the *Johnson v. Rank* settlement agreement, if a beneficiary spends part of the SOC on "non-covered" medical services or remedial services or items, the nursing facility will subtract those amounts from the beneficiary's SOC. The nursing facility will adjust the amount on the claim and Care1st shall pay the balance (i.e. Medi-Cal or contracted rates minus Covered Service SOC).

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Over the counter drugs cannot be billed on a beneficiary's SOC since these drugs are included in facility's per diem rate.

4. Determining How Much to Bill Care1st
   When a Medi-Cal beneficiary has an LTC aid code and a SOC, the Nursing Facility shall separate the covered services SOC from the Non-covered service SOC. Care1st will pay the difference of allowed amount minus the SOC amount for covered services. This also applies to SOC met in the beginning of the month. Care1st may validate SOC billed by Nursing Facility with the State eligibility tape and/or the Medi-Cal Eligibility Transaction website.
5. Services covered under Medicare must be billed to Medicare FFS or other Medicare Advantage plan prior to collecting SOC. The patient's liability is limited to the amount of the Medicare deductible and coinsurance.
6. Do not submit claim to Care1st if beneficiary has not met their SOC.

Crossover Claims:

1. Beneficiary has Medicare and Medi-Cal coverage under Care1st
   - Care1st D-SNP and Cal Medi-Connect benefit plans do not have copay, coinsurance or deductible.
   - Claims will be processed under the beneficiary's Medicare account first for the Medicare covered services
   - Medicare payment will be compared against Medi-Cal allowed amount.
     i. Medi-Cal allowed amount is less than Medicare allowed amount
        1. No additional payment will be made, Medicare payment will be the payment in full
     ii. Medi-Cal allowed amount is greater than Medicare allowed amount
        1. Difference of Medi-Cal allowed, SOC and Medicare amounts will be paid.
           a. Example: Medicare allowed amount is $2500; SOC is $100, Medi-Cal is $3500, additional reimbursement will be $900.
   - Provider will receive two Remittance Advices from Care1st, one under the Medicare account and the other under the Medi-Cal account
2. Beneficiary's Medicare coverage under Medicare FFS or under other Medicare Advantage Plans, Medi-Cal coverage under Care1st
   - Claim must be billed to Medicare FFS or other Medicare Advantage Plans first
   - Medicare EOB must be submitted with the claim
   - Care1st will pay the Medicare deductible, coinsurance and/or copay
     i. If Member has SOC, the coinsurance plus Medicare deductible minus SOC will be paid
     ii. If Medicare deductible, coinsurance and/or copay is more than difference between Medicare payment and Medi-Cal allowance, Care1st will pay the difference minus the applicable SOC
   - Claim must be billed with Care1st Medicare member number. The number must be entered on Field 60 of UB-04 form (Insured's Unique ID)
   - Provider will receive two Remittance Advices from Care1st, one under the Medicare account and the other under the Medi-Cal account
3. Claim must be billed with Care1st Medicare member number. The number must be entered on Field 60 of UB-04 form (Insured's Unique ID)
4. Paper claim must be billed to Care1st with copy of Medicare Evidence of Payment or Remittance Advice to the following address:

   Care1st Health Plan
   Mail Stop: CL005 (Claims COB)
   601 Potrero Grande Drive
   Monterey Park, CA 91755

5. Under no circumstances should a provider of Medi-Cal services submit claims to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal Managed Care Program's scope of benefits as well as any applicable Medicare deductibles or coinsurance

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Determining the Correct Payer

In order to determine the appropriate payer and where to submit the bill, please refer to the authorization.

- Medicare Beneficiary
  - Shared Risk IPA – IPA provides authorization for all services; Provider to bill Plan for facility charges.
  - Full Risk IPA – IPA provides authorization for all services; Provider to bill Full Risk Hospital partner for facility charges.
- Medi-Cal Long Term Care
  - All beneficiaries receive authorization and payment from the Plan.
- Medi-Cal Long Term Care with Medicare Part B
  - All beneficiaries receive authorization and payment from Plan.

CASE MANAGEMENT

Care Managers

Care1st has Care Managers. Care1st employs both social workers and licensed nurses to perform case management functions.

For members residing in nursing facilities, Case Managers work collaboratively with NF providers to ensure that members are at the appropriate level of care, needed covered benefits are accessed in a timely manner, and carved out services as well as community resources are effectively utilized. It is also a requirement from the state that Care1st assesses for patient willingness and capacity to return to community living and to facilitate that transition, if needed.

Contact Care1st

Please contact Care1st under the following circumstances for coordination:

1. New admission
2. New enrollment to Care1st Health Plan
3. Member transfer
4. Member expiration
5. Bed holds
6. Member departure from facility, against medical advice (AMA)
7. Admission to hospital
8. Member has a change in Level of Care
9. Request for ancillary services and equipment
10. General questions regarding authorizations, claims, billing, contracting

PLEASE NOTE: Direct care related issues and medical changes of condition should be referred to the attending physician as customary.

HEALTH RISK ASSESSMENT

The HRA

The HRA is a bio/medical/psycho/social/functional assessment. The health professional will interview the member and/or the member's representative using a tool that has been approved by the state and CMS.

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Conducting the HRA

Under most circumstances, face to face Health Risk Assessments with the patient will be performed by Care1st contracted health professionals at the facility.

TRANSPORTATION

Responsibility for Transportation to the Emergency Room

Medi-Cal Long Term Care Member:
Transportation for Medi-Cal Long Term Care transportation to the Emergency Room is the responsibility of Care1st.

Skilled Member:
Transportation for skilled to Emergency Room is the responsibility of Care1st except for full risk IPAs.

If the IPA is a full risk IPA, they are responsible for transportation to the Emergency Room.

LEAVE OF ABSENCE AND BEDHOLDS

Care1st will include any leave of absence or bedhold as a covered benefit if provided in accordance with Title 22 California Code of Regulations or California's Medicaid State Plan.

CONTINUITY OF CARE

Care1st will follow DPL 13-005 as it pertains to how we will administer NF Services. Refer to claims section for payment for OON providers.

CHANGE IN COVERAGE, CONDITION OR DISCHARGE

The NF can modify its care of a beneficiary or discharge the beneficiary if:

- The NF is no longer capable of meeting the beneficiary's health care needs;
- The beneficiary's health has improved so that he or she no longer needs NF services; or
- The beneficiary poses a risk to the health or safety of individuals in the nursing facility.

Care1st will request documentation from the NF to verify that the modification was made for an allowable reason.

Appealing a Discharge

A beneficiary may appeal a discharge. Please see the Care1st website at
https://www.care1st.com/ca/calmediconnect/member_resources.asp?resource=AppealsProcess#memres

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DELEGATION OVERSIGHT

Care1st will conduct delegation oversight. Details associated with oversight activities will be communicated via a separate audit/oversight tool.

NF DELEGATION FOR SHORT TERM SKILLED CARE

The NF's responsibility when the beneficiary belongs to an IPA is:

1. The IPA IP Case Manager will coordinate approval to NF.
2. The NF will obtain the authorization from the IPA.
3. The IPA will obtain daily clinical from NF and perform concurrent review.
4. IPA decisions will be submitted to Care1st via FTP site on a weekly basis.

Care1st's role when the beneficiary belongs to an IPA:

1. The NF notifies Care1st of the admission.
2. Care1st will note on the Face sheet if IPA is delegated for NF concurrent review and to contact the IPA.
3. Care1st will contact the IPA designee to obtain updates on all prolonged stays at the NF on a weekly basis until the member is discharged and assist IPA with any discharge planning needs if required.

NF BEHAVIORAL HEALTH

Care1st has a dedicated behavioral team. The behavioral health component is shared between Care1st and the NF to ensure that this is covered for NF residents.

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Authorization required for services listed below.
Prior Authorizations are required for elective services.
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), Electroconvulsive Therapy (ECT).
  - Non MD/APRN BH Outpatient Visits & Community Based Outpatient programming: After initial evaluation for outpatient and home settings.
  - Medicare does not require authorization for outpatient behavioral health services.
- **Chiropractic Services**
- **Dental General Anesthesia:** >7 years old or per state benefit (Not a Medicare covered benefit).
- **Dialysis:** Notification only.
- **Durable Medical Equipment:** Refer to Care1st's website for specific codes that require authorization.
  - Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462.
- **Home Healthcare**
- **Home Infusion**
- **Hospice & Palliative Care**
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, Intimal Media Thickness Testing, Three Dimensional (3D) Imaging.
- **Inpatient Admissions: Non-Emergent Acute hospital, Nursing Facilities (NF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only).
- **Long Term Services and Supports:** In Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Mulitpurpose Senior Services Program (MSSP), Long Term Care (LTC).
- **Neuropsychological and Psychological Testing and Therapy**
- **Office visits, procedures, labs, diagnostic studies, inpatient stays**
- **Nutritional Supplements & Enteral Formulas (Under special circumstances)**
- **Occupational Therapy:** After initial evaluation for outpatient and home settings.
- **Specialist Referrals**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Care1st's website for specific codes that are **EXCLUDED** from authorization requirements.
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Acupuncture is not a Medicare covered benefit).
- **Physical Therapy:** After initial evaluation for outpatient and home settings.
- **Prosthetics/Orthotics**
- **Rehabilitation Services:** Including Cardiac, Pulmonary, and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only.
- **Sleep Studies.**
- **Specialty Pharmacy drugs (oral and injectable) used to treat the following disease states, but not limited to: Anemia, Crohn's/Ulcerative Colitis, Cystic Fibrosis, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiencies, Multiple Sclerosis, Oncology, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, and RSV prophylaxis:** Refer to Care1st's website for specific codes that require authorization.
- **Speech Therapy:** After initial evaluation for outpatient and home settings.
- **Transplant Evaluation and Services**
- **Transportation:** non-emergent ambulance (ground and air).
- **Wound Therapy including Wound Vacs and Hyperbaric**

IMPORTANT INFORMATION FOR CARE1ST HEALTH PLAN

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone/fax or electronic notification. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition. Providers can request a copy of the criteria used to review requests for medical services by contacting the Care1st UM department at 844-200-0121 (Los Angeles) or 855-303-2232 (San Diego).

Providers may register and verify eligibility using the portal https://online.care1st.com/ca/provider_login.

*This guide is subject to future revisions based on updates or changes to program requirements.

CARE1ST DEPARTMENTS CONTACT LIST

CARE1ST DEPARTMENTS ◆ Los Angeles County

Name	Phone Number	FAX Number
Coordinated Care Initiative	855-905-3825	323-889-2100
Home Health	323-889-6638 x6176	323-889-6574
MLTSS/Long Term Care	855-622-2755	844-200-0121
Social Services	877-221-0208	323-889-2019
UM, Outpatient	323-889-6638 x6122	323-889-6577
UM, Inpatient	323-889-6638 x6128	323-889-6579

CARE1ST DEPARTMENTS ◆ San Diego County

Name	Phone Number	FAX Number
Coordinated Care Initiative	855-905-3825	844-200-0114
Home Health	619-528-4800	855-332-0377
MLTSS/Long Term Care	855-622-2755	844-200-0121
Social Services	619-528-4800	323-889-6506
UM, Outpatient	619-528-4800	323-889-6506
UM, Inpatient	619-528-4800	323-889-6573

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