Skilled Nursing Facilities Handbook

By: Optum Public Sector San Diego
3rd Edition – August 1, 2016

Hello,

The Skilled Nursing Facilities Handbook has been revised to reflect the updates related to Medi-Cal Share of Cost and ICD-10 requirements for the County of San Diego Behavioral Health Services Mental Health Plan (MHP).

When reviewing the new handbook, please pay close attention to the following:

- **Share of Cost**

  Share of Cost (SOC) is a monthly client liability amount (determined by the state) that is based on a client's ability to pay. The SOC must be paid by the client each month for services received during the month and prior to the provider being reimbursed by the County of San Diego. The client's share of cost will be automatically deducted from the reimbursement made to the SNF on behalf of the County of San Diego.

- **ICD-10**

  The use of ICD-10 Codes (International Classification of Disease) for Billing commenced on an industry wide basis on October 1, 2015. All references to the use of ICD-9 codes have been changed to incorporate the transition to the use of ICD-10 codes.

- **Optum Public Sector San Diego's Website**

  On November 1, 2015 Optum Public Sector San Diego introduced a new and improved website that can be found at www.optumsandiego.com.

Please visit our new website at www.optumsandiego.com to download forms or to save the handbook and forms to your desktop for easy access.

Optum Provider Services staff can be reached at (800) 798-2254, option 7 with any questions about the updated handbook. Thank for working with Optum Public Sector in serving the County of San Diego Medi-Cal beneficiaries.

Best Regards,

Judy A. Duncan-Sanford

Judy A. Duncan-Sanford, MFT
Manager of Provider Services

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Introduction

Optum Public Sector San Diego contracts with Skilled Nursing Facilities (SNF) on behalf of the County of San Diego Behavioral Health Services (BHS). The services rendered in the County Funded SNFs are governed by the contract with Optum Public Sector San Diego, the policies and procedures in this handbook, as well as the Federal, State, and local laws governing services rendered in SNFs. Providers are encouraged to review these documents closely.

This Skilled Nursing Facilities Handbook was developed to give facilities information about the Contracting, Authorization, Utilization Management, Billing, and Issues Resolution procedures for the County Funded network of SNFs. An electronic version of the handbook is available online at the Optum Public Sector San Diego website under Skilled Nursing Facilities Forms.

Take note:

An electronic version of this handbook, as well as helpful forms regarding County Funded Skilled Nursing Facility services, is available online at the Optum Public Sector San Diego website:

www.optumsandiego.com

The Role of Optum Public Sector San Diego

In its role as the Administrative Services Organization (ASO) for the County of San Diego's publicly funded behavioral health system, Optum Public Sector San Diego:

- Credentials and contracts with SNFs
- Authorizes County Funded SNF and Long Term Care (LTC) services
- Processes and pays claims for SNFs
- Conducts medical necessity and utilization management review on SNF Subacute services
- Operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care, including substance abuse services, referral and information for mental health
- Facilitates access to emergency mental health services for residents of San Diego County

For general information, Optum Public Sector San Diego can be reached at (619) 641 - 6800. In addition, the Optum Public Sector San Diego website provides links to this handbook and helpful documents regarding SNF services.

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Directory

- **Optum Public Sector San Diego**

  P. O. Box 601340

  San Diego, CA 92160-1340

- **Optum Provider Line: (800) 798 – 2254**
  - Provider Services: Option 7
    - Contracting
    - Credentialing
    - Recredentialing
  - Long Term Care: Option 6
    - Authorization for SNF services
    - Clinically related questions
    - General questions about County Funded SNFs
  - Billing & Claims: Option 2

- **Optum Long Term Care Fax Line: (888) 687 – 2515**

- **Optum Provider Services Fax Line: (619) 641 – 6975**

- **Optum Public Sector San Diego: (619) 641 – 6800**
  - General information

- **Optum Public Sector San Diego Website:**

  www.optumsandiego.com

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Contracting, Credentialing and Recredentialing Process

Optum Public Sector San Diego, on behalf of the County of San Diego Behavioral Health Services (BHS), is responsible for developing and maintaining a network of Skilled Nursing Facilities (SNF). All County Funded SNFs are required to contract with Optum Public Sector San Diego, in order to receive reimbursement for services rendered to clients.

Contracting

The contracting process begins with the completion of a SNF Application, submission of credentialing documents (identified below) and review of the documents through the United Healthcare Credentialing Committee. Optum Provider Services staff is available to discuss the application process and to assist facilities with completing the application.

The United Behavioral Health, Public Sector San Diego Skilled Nursing Facility Agreement (operating under the brand of Optum) was developed in conjunction with County Behavioral Health Services (BHS) and contains:

- The Facility Agreement with general terms applicable to contractors delivering county services
- Exhibit "A" Services and Rates with Revenue Codes and reimbursement schedules
- This handbook is included by reference in the contract.

All SNFs are required to follow the contracting, credentialing and recredentialing requirements. Please contact Optum Public Sector San Diego Provider Line at (800) 798-2254, Option 7, with any questions pertaining to the contract process.

Take note:

Please contact Optum Provider Line at (800)798-2254, option 7

- To update information
- With question regarding Contracting, Credentialing, or Recredentialing

Credentialing

The Credentialing of SNF facilities is performed by UnitedHealthcare (UHC) for Optum Public Sector San Diego Provider Services, and includes documentation review and primary source verification. All SNFs are required to complete a UnitedHealthcare Facility Credentialing and Recredentialing Application as part of the initial contracting process. The following documents are reviewed:

- Facility's State License
- Medicare/Medi-Cal Certification
- Employer Liability Insurance
- Professional Liability Insurance
- Comprehensive Liability Insurance

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- Professional Errors and Omissions Liability Insurance
- Medicare/Medi-Cal Sanctions Report
- Improper Sexual Contact Coverage
- Copy of most recent State Agency Site Review or CMS Certification Approval Letter
- Malpractice history and complaints documented with the National Practitioner Data Bank (NPDB), Regional Medicare/Medi-Cal offices, and the State medical boards or other appropriate State agency
- Facility NPI number

Recredentialing

UHC performs recredentialing of all SNF facilities on behalf of Optum Public Sector San Diego. The recredentialing process occurs at a minimum of every 36 months from the most recent credentialing or recredentialing date. UHC will send a *UnitedHealthcare Facility Credentialing and Recredentialing Application* directly to the SNF to complete and return to them. This recredentialing process enables Optum Public Sector San Diego to verify that the SNF continues to meet the credentialing criteria required to contract with Optum Public Sector San Diego.

The recredentialing process includes documentation review and primary source verification of documents reviewed during the original credentialing process.

Additional areas reviewed during the recredentialing process include:

- Facility data such as complaints and compliance with Principles of Care (provided in this handbook)
- Compliance with contract obligations and the Optum Public Sector San Diego authorization procedures

Facilities can help avoid delays at recredentialing time by updating credentials on an on-going basis. Facilities that delay updating documentation may not be able to obtain ongoing authorizations, or claims reimbursement until all documentation is up to date. For instance, changes to a Tax ID or mailing addresses will adversely affect how quickly payment can be made. A facility may be required to furnish additional background information or to authorize a background investigation based upon new or additional information. Facilities that do not submit the required recredentialing documentation after outreach by Provider Services staff shall have their contracts terminated.

Take note:

Please contact Optum Provider Line at (800)798-2254, option 7

- To update information
- With question regarding Contracting, Credentialing, or Recredentialing

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Principles of Care

The following Principles of Care apply to all clients receiving services:

- **Care Should Promote the Client's Recovery:** Clients have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Clients also have the right to information that will inform decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.
- **Care Should Be Accessible:** Optimal clinical outcomes result when access to the most appropriate and available level of care is facilitated at admission and when transitioning between levels of care. A client's transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to provider at the next level of care.
- **Care Should Be Appropriate:** Optimal clinical outcomes results when evidence-based treatment is provided in an available level of care, and the proposed care stems from the client's current condition. The level of care should be structured and intensive enough to safely and adequately treat a client's presenting problem and support his/her recovery.

  Treatment planning should take into account significant variables such as the client's current clinical need, age and level of development, whether the proposed services are covered in the client's benefit plan, whether the proposed forms of treatment are evidence-based, whether the proposed services are available in or near the client's community, and whether community resources such as self-help and peer support groups, consumer-run services, and preventive health programs can augment treatment. Also a less restrictive setting in which a client may be effectively treated is unavailable.
- **Care Should Be Effective:** There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care will improve the client's presenting problems within a reasonable period of time. "Improvement in this context is measured by weighing the effectiveness of treatment and the risk that the client's condition is likely to deteriorate or relapse if treatment in the current level of care were to be discontinued. Improvement must also be understood within a recovery framework where services support movement toward a full life in the community.

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Utilization Management and Authorizations

Optum Public Sector San Diego Clinical Utilization Management

Optum Clinical Utilization Management (UM) is responsible for providing initial and continued stay authorizations for clients that meet County of San Diego Funded SNF Admission and Continued Stay Criteria (provided in this handbook). Requests for initial authorizations are accepted from SNFs when a client is already a resident at the SNF and the client's funding is changing from Medi-Care or Medi-Cal to a Medi-Cal Managed Care Plan. Referrals are also accepted from Lanterman-Petris-Short (LPS) - Designated Acute Care Psychiatric Hospitals. Written clinical information provided by SNF or hospital to Optum is reviewed by Optum Clinical Care Advocates and Optum Medical Director to determine whether Admission is met.

Take note:

Optum Public Sector Clinical Utilization Management Contact

Provider Line:
(800) 798 – 2254,
Option 6: LTC (Authorization)

Long Term Care Fax:
(888) 687 – 2515

Mailing Address:
Optum Public Sector
PO Box 601340
San Diego, CA 92160 – 1340

Admission Criteria for County Funded Skilled Nursing Facilities

A Skilled Nursing Facility is required to have sufficient staff and equipment to provide skilled nursing care, rehabilitation, custodial care, and other related health services to clients who need nursing care, but do not require hospitalization.

The client is required to meet the following required criteria for County Funded SNF:

1. Is a current resident of the State of California and has Medi-Cal eligibility for the County of San Diego.
2. Is at least 18 years of age.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, Medi-Care, or private insurance.
4. Cannot be safely managed in a less restrictive level of care. Documentation is provided to show that all other alternatives including Augmented Service Program Board and Care, traditional Board and Care, Full Service Partnership case management, and traditional case management have been attempted or there is documentation that these alternatives alone are not able to meet the client's needs.
5. Clients that appear to meet criteria to be covered by a MCP must be referred to the MCP for determination prior to be considered for County Funded SNF. Clients with no or minimal medical acuity conditions will not require prior denial determination from the MCP.
6. Client's primary focus of treatment is not a physical health condition that would require skilled nursing care.'
7. Is currently being treated in an LPS psychiatric hospital or is in an SNF/LTC bed currently funded by San Diego County.

Take note:

The primary focus of treatment is a Title 9 DSM-IV-TR Axis I diagnosis. The primary focus of treatment cannot be a physical condition that would require SNF care.

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8. Requires 24/7 residential care with both a nursing component and a psychiatric component.
    a. IMD level of care was deemed as inappropriate level of care due to physical health needs, age, or not currently able to participate in a 21 hour per week psychosocial rehabilitation program.
9. Has exhibited the need for this level of care based on the client either being gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by the Superior Court or is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
10. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
11. Is not at imminent risk of serious harm to self or others.
12. Has a tuberculosis (TB) clearance within thirty days of application.

And the client must meet at least <u>one</u> of the following clinical criteria:

    a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting.
    b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

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Initial Referral to County Funded Skilled Nursing Facilities

How to Make a Referral to County Funded SNF if the Client is a Current Resident in a SNF

If a client is a resident of a SNF and the client appears to meet criteria for a County Funded SNF bed, please follow these steps:

- Review the Admission Criteria for County Funded SNF to assess the client's appropriateness for referral and authorization through Optum.
- If client appears appropriate for referral, compile packet, and submit to: Optum LTC Fax: (888) 687-2515. See chapter Documentation Needed for SNF Referral Packets about completing referral packets.
- Optum staff will review the documentation. It is in the facility's best interest to ensure that documentation is complete and accurate so that Optum staff can make a timely and appropriate authorization decision. When the client meets the Admission Criteria for County Funded SNF, Optum will verbally notify the SNF employee making the referral and will send an authorization letter via USPS to the facility. When the client does not meet County Funded SNF admission criteria, Optum will verbally notify the SNF employee making the referral and send a *Letter of Determination* (LOD) to the fax number provided by the SNF. The reasons for denial and appeal information will be provided in the faxed LOD. The LOD will be addressed to the attending psychiatrist making the referral.

Take note:

Clients with a significant level of impairment as a result of a medical condition, require a written denial of authorization for SNF level of care from their Managed Care Plan.

How to Make a Referral to County Funded SNF if the Client is in an Acute Care Psychiatric Hospital

Clients in an acute care psychiatric hospital can be referred to a County Funded SNF bed if the client has a Title 9 mental health diagnosis that prohibits the client from being managed at a lower level of care. Please follow these procedures when a client is being referred from an acute psychiatric hospital:

- Review the Admission Criteria for County Funded SNF to assess the client's appropriateness for referral and authorization through Optum. Verify that the client has County of San Diego Medi-Cal funding.
- If appropriate for referral, compile packet, and submit to: Optum LTC Fax: (888) 687-2515
- If client meets County Funded SNF admission criteria, Optum will fax or secure e-mail a *Notification of Approval for Placement in a San Diego*

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County Funded SNF to the referring hospital. The hospital is responsible for finding placement in a SNF that will accept the client and that is contracted, or willing to contract, with Optum Public Sector San Diego for the County Funded SNF program.

After the hospital secures placement in a County Funded SNF, the hospital will inform Optum Public Sector San Diego in writing of the discharge rate from the hospital and the name of the SNF where the client is placed. The hospital may return the notification form with this information filled out by fax to (888) 687-2515.

How to Make a Referral to County Funded SNF if the Client Has a Physical Health Condition That Requires Skilled Nursing Care

Facilities referring clients to a SNF for skilled nursing care due to a physical health condition are required to follow the referral procedures by the client's funding source. If a client has a Medi-Cal Managed Care Plan (MCP), the referring facility contacts the MCP for information on the referral process. Optum is not involved with the process of referring clients to a SNF due to a physical health condition.

Documentation Needed for County Funded SNF Referral Packets

The following documentation is requested by Optum for all referrals to a County Funded SNF bed. This documentation is provided to Optum by the referring facility (a FFS hospital, a SNF, an IMD, or other facility):

1. SF/LTC Referral Form with attending psychiatrist's order for SF/LTC attached
2. Facility Face Sheet
3. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the facility business office) for County of San Diego
4. Most recent Court Investigation Report for County of San Diego LPS Conservatorship
5. Complete Psychiatric Assessment from current facility including psychiatric history, substance abuse history and history of self-destructive or assaultive behavior
6. Cognitive assessment (e.g., Mini-Cog™, MDS)
7. Physical and Medical History from current placement
8. Nursing Assessment from current placement

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9. Social Work Assessment and Notes from current placement
10. One week of progress notes including nursing, group, and psychiatrist
11. Medications including Medication Administration Record documenting medication compliance and information on medication changes
12. Lab reports
13. Results of purified protein derivative (PPD) (tuberculosis [TB] test) or chest x-ray when past 30 days
14. Written recommendation from the assigned Case Management program funded by the County of San Diego. If client is not assigned a Case Management program funded by the County of San Diego, then documentation that client will be assigned to a Case Management program funded by the County of San Diego

Initial Authorization for County Funded Skilled Nursing Facilities

Optum Clinical Utilization Management (UM) is responsible for providing an initial authorization for clients who meet Admission Criteria for County Funded SNF (provided in this handbook). After Optum approves a client for admission to a County Funded SNF (see Initial Referral to County Funded SNF section), the admitting County Funded SNF is responsible for informing Optum in writing of the date of admission to the County Funded SNF bed. This is the date that the SNF facility is requesting County funded payment to begin. Please follow these steps:

- The County Funded SNF needs to complete the *Verification of Admission and Request for Initial Authorization to County Funded SNF* (see Optum website, SNF section) and faxes the request to Optum LTC Fax at (888) 687-2515
- An initial 90 day authorization will be issued by Optum staff and an authorization letter will be mailed by USPS to the SNF facility. If requested by the admitting SNF, Optum staff will call the SNF contact person with the authorization number
- Additional authorizations follow the Continued Stay Authorization Process outlined in this handbook

Take note:

A SNF may appeal a denial of an Initial Authorization request or a Continued Authorization Request by calling Optum Provider Line, Long Term Care at (800) 798-2254, Option 6.

Continued Stay Criteria for County Funded Skilled Nursing Facilities

Optum UM staff will conduct a concurrent review 90 days from date of admission. Subsequent concurrent reviews will be at a frequency based on clinical presentation. The subsequent reviews will be no less than 30 days and no more than 180 days from the last review and are dependent on clinical documentation, level of impairment, and progress towards discharge plan.

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The client is required to meet the following criteria for continued stay in a County Funded SNF:

1. The client continues to meet the admission criteria for the current level of care.
2. The client continues to present with symptoms and/or history that demonstrate a significant likelihood of deterioration in functioning/relapse if transitioned to a less intensive level of care.
3. The treatment being provided is appropriate and of sufficient intensity to address the client's condition and support the client's movement toward recovery.
4. The treatment plan is accompanied by ongoing documentation that the client's symptoms are being addressed by active interventions; the interventions focus on specific, realistic, achievable treatment and recovery goals that are appropriate to the client's strengths, problems and situation; and designed to prevent relapse and measure progress toward discharge.
5. Measurable and realistic progress has occurred or there is clear compelling evidence that continued treatment at the current level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care.
6. The client requires the current level of care in order to move toward recovery.
7. There is an appropriate discharge plan to a less restrictive level of care or for termination of treatment that takes into account the client's recovery goals and preferences, and allows for treatment gains to be maintained/enhanced.
8. Responsible Managed Care Plan re-evaluated client, as clinically indicated or as appropriate, and written documentation is provided indicating that the client does not meet the Managed Care Plan's SNF Level of Care criteria.
9. Client's primary focus of treatment is not a physical health condition that would require skilled nursing care.

And the client must meet at least one of the following clinical criteria.

   a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.

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b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF level of care is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Continued Stay Authorization for County Funded Skilled Nursing Facilities

Optum Clinical Utilization Management (UM) is responsible for continued stay authorizations for clients who meet Continued Stay Criteria for County Funded SNF. Concurrent reviews are used to request additional authorization from Optum and need to be submitted prior to the end of the current authorization. Delays in submitting the continued authorization information can delay claims payment. Authorizations and concurrent reviews are done at a frequency determined based on clinical presentation. The review will be no less than 30 days and no more than 180 days from last authorization; dependent on clinical documentation, level of impairment, and progress towards discharge plan. Please follow these procedures when requesting a continued stay authorization and submitting a concurrent review:

- The County Funded SNF is required to request continued stay authorization at least 14 business days prior to the end of the current authorization. The end date of the current authorization is included on the most recent authorization letter mailed to the SNF
- Review the Continued Stay Criteria for County Funded SNF to assess the patient's appropriateness for continued stay through Optum. Confirm that the client has County of San Diego Medi-Cal funding
- If client appears appropriate for continued stay, complete the *Concurrent Review Guide for County Funded SNF* (located on the Optum Public Sector San Diego website, SNF section), and submit with the clinical information listed in the *Concurrent Review Guide* to: Optum LTC Fax: (888) 687-2515
- Optum staff will review the documentation and make a determination within 14 business days of receiving complete information

Take note:

A SNF may appeal a denial of an Initial Authorization request or a Continued Authorization Request by calling Optum Provider Line, Long Term Care at (800) 798-2254, Option 6 .

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- Of client meets the Continued Stay Criteria for County Funded SNF, Optum will authorize between 30 days and 180 days for continued treatment. Optum will send an authorization letter with the date of the final day authorized via USPS to the facility.

- If the client does not meet Continued Stay Criteria for County Funded SNF, Optum will issue a *Notice that Continued Stay Criteria is Not Met* and will approve at least 30 days after the final day authorized to dive the SNF time to arrange placement. The *Notice that Continued Stay Criteria is Not Met* will include reasons for denial and how to appeal the denial. The notice will be addressed to the attending psychiatrist treating the client. Optum will verbally notify the SNF employee making the referral and send a *Letter of Determination* (LOD) to the fax number provided by the SNF.

Bed Hold Days for County Funded SNF Clients

When the County Funded SNF anticipates readmitting a client, the SNF can request a Bed Hold when a client is admitted to a hospital for acute care (either for a psychiatric or physical health reason) or Absent without Leave (AWOL) from the SNF. If the SNF does not anticipate re-admitting the client, the SNF follows the Discharge from County Funded SNF Procedures.

Optum will approve a bed hold of up to seven (7) days for a hospital admission due to psychiatric or physical health reasons. A Bed Hold of up to three (3) days will be approved when a client's AWOL from the County Funded SNF. *Please note*: the only reasons for requesting a Bed Hold are: admission to an acute care hospital or AWOL when the SNF is willing to readmit the client.

Please follow these procedures when requesting a Bed Hold:

- SNF Facility notifies Optum Utilization Management in writing when a client becomes AWOL or is admitted to a hospital. Complete the *Bed Hold Request Form* (located on the Optum Public Sector San Diego website, SNF section) and fax the *Bed Hold Request* to Optum LTC Fax at (888) 687-2515.

- Optum clinical staff will review the request and approve a Bed Hold of up to seven (7) days for a hospital admission or up to three (3) days for when a client is AWOL. Optum staff will fax approval of the bed hold days to the requesting SNF at the fax number provided by the SNF.

  If a client returns to the SNF prior to the end of the Bed Hold, the SNF Facility notifies Optum Utilization Management in writing with the date the client is re-admitted to the SNF. This notification is required at the time of the client's re-admission to the County Funded SNF. The SNF completes the *Notification of Return to County Funded SNF Bed Hold Form* (located on the Optum Public Sector San Diego website, SNF section) and faxes the form to Optum LTC Fax at (888) 687-2515.

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Optum staff will provide written confirmation by fax to the SNF at the fax number provided by the SNF.

- If a client does not return to the SNF by the end of the Bed Hold, the SNF facility is required to discharge the client as of the day after the Bed Hold ends.
- Please follow the Discharge from County Funded SNF procedure (provided in this handbook).

Discharge From County Funded SNF

The County Funded SNF is required to inform Optum in writing at the time of a client's discharge from the County Funded SNF. The SNF is also required to coordinate the discharge with the client's case manager, conservator, legal representative, and family as appropriate. In addition to coordinating with those involved with the client, please follow these procedures when discharging a client from a County Funded SNF:

- SNF Facility notifies Optum Utilization Management in writing at the time of a client's discharge from the SNF. This is done by completing the *Notification to Optum of Discharge from County Funded SNF Form* (located on the Optum Public Sector San Diego website, SNF section) and faxing the form to Optum LTC Fax at (888) 287-2515. Please note: the day of discharge is not a billable day.
- Optum staff will acknowledge receipt of the discharge information by fax to the number provided by the SNF.

Long Term Care Forms for County Funded SNF

The following Long Term Care Forms are available online at the Optum Public Sector San Diego website under the Skilled Nursing Facilities Forms section:

- *Fax Cover Sheet to Optum*
- *Verification of Admission and Request for Initial Authorization to County Funded SNF*
- *Documentation Needed for Referral for County Funded SNF*
- *Mini-Cog™ Exam*
- *Recommendation for Case Manager*
- *Referral Screening Form*
- *Tips for Completing Referral Screening Form*
- *Concurrent Review Guide for County Funded SNF*
- *Bed Hold Request Form*
- *Notification of Return to County Funded SNF From Bed Hold*
- *Notification to Optum of Discharge from County Funded SNF*

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Procedure for Submitting County Funded SNF Appeals

When a SNF submits a request to admit a client or to continue a client's stay at the SNF, Optum will review the documentation submitted for the admission or continued stay. Optum staff will respond to the request with either a *Letter of Determination* or a *Notice That Criteria for Continued Stay is Not Met*.

There are times when a facility may disagree with Optum regarding a clinical determination. Facility staff is encouraged to communicate any issue or concern regarding clinical decisions to Optum. Optum is committed to responding in an objective and timely manner. A facility may appeal a denied or modified request for payment authorization. Facilities that wish to pursue an appeals process regarding authorization for reimbursement of services have the right to access the appeals process at any time. The written appeal should be submitted to Optum Public Sector within five (5) business days of the date of receipt of the non-approval of payment.

The SNF can request an appeal when the attending psychiatrist, conservator or client disagrees that the criteria on the letter or notice was not met. The facility is required to include in writing all relevant data, documents or comments that support the necessity for SNF services. Information to support the appeal includes:

- A written appeal request on the designated appeal form included with the letter or notice by Optum
- Supporting documentation that explains how the client meets the Continued Stay Criteria for County Funded SNF.
- Clinical records supporting the existence of medical necessity, if at issue
- A summary of the reasons why the services should be authorized.
- The appeal must be requested within five (5) business days of receipt of the letter or notice.
- Mail or fax the appeal form and the supporting documentation to:

  Optum, Quality Improvement Department
  PO Box 601370
  San Diego, CA 92160-1370
  Fax: (866) 220-4495

Optum processes the appeal and supporting documentation and forwards to the County of San Diego Quality Management Department for consideration. The County of San Diego will review the documentation and send Optum a determination letter within. Optum will forward the County's determination letter to the SNF. The appeal process will take approximately 15 business days.

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Procedure for Submitting County Funded SNF Administrative Day Requests

When a SNF receives a *Notice that Criteria for Continued Stay is Not Met*, and the client meets criteria for a lower level of care, but no placement is available, the SNF may submit a request for Administrative Days for the client. The Administrative Days are paid at the same rate and allow for more time to secure placement.

When submitting a request for Administrative Day, please follow these steps:

- Facility or County Case Management Program Manager submits a written request for administrative days on the designated form, along with any supporting documentation at least two (2) weeks prior to the end of the authorization. The designated request form is included with the *Notice that Criteria for Continued Stay is Not Met*.
- Mail or fax written request to:

  Optum, Quality Improvement Department
  PO Box 601370
  San Diego, CA 92160-1370
  Fax: (866) 220-4495

- Optum Quality Improvement staff will process the request and forward it to the County of San Diego Quality Management Department within two (2) business days of receipt of request.
- The County of San Diego staff will review the supporting documentation and makes a determination that includes the number of Administrative Days granted and the last day authorized.
- Optum Quality Improvement staff will forward the County's determination to the facility. The request for Administrative Days will take approximately 15 business days.

Take note:

Please contact the Optum Quality Improvement department at (619) 641 – 6216 with questions about the process.

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Claims and Billing

Optum Public Sector San Diego, on behalf of the County of San Diego, is responsible for the reimbursement of claims for County Funded Skilled Nursing Facilities (SNF). Please follow the billing procedures described in this section.

Verification of Medi-Cal Eligibility

SNF providers are required to verify Medi-Cal eligibility for each month of service. The state eligibility system is updated on the 1st of each month. Verifying eligibility provides critical information including:

- Medi-Cal coverage type (Aid Code)
- County of Residence (37 to bill San Diego Medi-Cal)
- Other insurance coverage
- Ineligible Aide Code

It is the responsibility of the facility rendering services to verify eligibility by calling the Automated Eligibility Verification System (AEVS) at (800) 456-AEVS (2387), or using the website http://www.medi-cal.ca.gov. Facilities must have a valid PIN/User ID to access AEVS and may call (800) 541-5555 for assistance obtaining a temporary PIN.

Disbarment and Exclusions Requirement and Monthly Attestation Letter

SNF contracted with Optum, on behalf of the County of San Diego Behavioral Health Services, shall not employ anyone listed as an ineligible person by the Office of the Inspector General (OIG). An "Ineligible Person" is an employee who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. SNFs are required to confirm on a monthly basis, that employees are not listed as ineligible by checking the following website: www.exclusions.oig.hhs.gov.

Take note:

Provider Services must receive the signed Attestation at the end of each month in order for claims to be paid timely.

In addition to checking the OIG, SNFs may not employ anyone identified as an “Ineligible Person” by the California Department of Health Services (CDHS) in providing care or services through this contract. Any employee(s) of the SNF who is determined to be an “Ineligible Person” cannot care for or be involved with clients whose services are paid for by the County of San Diego. An "Ineligible Person" in this scenario is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. SNFs are required to verify on a monthly basis,

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the eligibility of staff working with County of San Diego clients by checking the following website: http://www.medi-cal.ca.gov (search under "MediCal Suspended and Ineligible List").

By the last day of each month, the SNF is required to submit a signed attestation that none of its employees are listed as an "Ineligible Person" on the OIG and the Medi-Cal websites listed above. After confirming the eligibility of employees, the SNF is required to sign the *Disbarment and Exclusions Requirement Monthly Attestation Form* and fax it to Optum Provider Services at (877) 309 - 4862. Optum claims staff is able to adjudicate claims very quickly; however, claims payment will be held until the signed *Disbarment and Exclusions Requirement Monthly Attestation Form* is received by Optum Provider Services. The required attestation form to be submitted to Provider Services is located online at the Optum Public Sector San Diego website under the Skilled Nursing Facilities Forms section.

Submitting Claims for County Funded Skilled Nursing Facilities

Facilities are required to mail County of San Diego Funded SNF claims to the following address:

Optum Public Sector San Diego/ SNF
P.O. Box 601340
San Diego, CA 92160-1340

Claims submission procedure:

1) All claims must be submitted within 120 days from the month of service.
2) All claims must be submitted using an original UB-04.
3) The following data elements must be included on the form UB-04. Claims submitted without these data elements will be denied.
   a) **Box 1** - Facility Name, Address, Telephone and County, Zip Code
   b) **Box 2** - Pay-to Name and Address the provider submitting the bill.
   c) **Box 4 -** Type of Bill – This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient of outpatient.
   d) **Box 5** - Federal Tax Number – Assigned by federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN).
   e) **Box 6** - Statement Covered Period "From" and "Through" – Used this field to report the beginning and end date of service for the period reflected on the claim MMDDYY.

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f) **Box 8b** – Patient Name – This field is for the patient's last name, middle initial, and first name.

g) **Box 9a** - Patient Address – This field is for entering the patient's street address, or P.O. Box or RFD, city, state, ZIP code.

h) **Box 9b** - City Address - This field is for entering the patient's city.

i) **Box 9c** – State – This field is for entering the patient's State code.

j) **Box 9d** – ZIP Code – This field is for entering the patient's ZIP code.

k) **Box 10** - Patient Birth Date – Field includes the patient's complete date of birth using the eight-digit formant (MMDDCCYY).

l) **Box 11** – Patient Sex – Use this field to identify the sex of the client. Enter M for male or F for female.

m) **Box 38** - Responsible Party Name and Address – This field is for reporting the name and address of the person responsible for the bill.

n) **Box 42** - Revenue Code – Report the appropriate HIPPA compliant numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/ancillary service. Below is the ID Revenue Code with description.

Revenue Code	Revenue Code Description
0185	Bed Hold
0190	Subacute
0191	Subacute Level I
0192	Subacute Level II
0193	Subacute Level III
0194	Subacute Level IV
0199	Other Subacute

o) **Box 44** - HCPCS/ Rate/ HIPPS Code – Is used to report the appropriate HCPC Codes for ancillary service, the accommodation rate for bills for inpatient services, SNF Health Insurance Prospective Payment Systems rate codes for specific patient groups that are the basis for payment under a prospective payment system.

p) **Box 46** - Service Units – The number of inpatient SNF days are reported.

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q) **Box 47** - Total Charges – The field reports the total charges covered and non-covered related to the current billing period.

r) **Box 50** - Payer Name - If more than one payer is responsible for the claim; enter the names of primary, secondary and tertiary payers as applicable.

s) **Box 58** - Insured's Name (last, first name, middle initial) the name of the individual who carries the insurance benefits is reported in this field. This must match the name of the insured's BIC Number.

t) **Box 60** - Insured's Unique ID – This is the unique number that Medi-Cal assigns the client to insured the individual Medi-Cal Benefits Identification Card (BIC).

u) **Box 66** - Diagnosis Code – This is ICD-10 CM being used is required in this field for the UB-04, you must enter all diagnosis billed based on UB-04.

An example of the form UB-04 can be found online at the Optum Public Sector San Diego website under the Skilled Nursing Facilities Forms section.

Share of Cost

Share of Cost (SOC) is a monthly client liability amount (determined by the state) that is based on a client's ability to pay. The SOC must be paid by the client each month for services received during the month and prior to the provider being reimbursed by the County of San Diego. The client's share of cost will be automatically deducted from the reimbursement made to the SNF on behalf of the County of San Diego.

Claims Processing Procedures

All claims must be submitted within 120 days from the month of service. Clean claims will be processed within 30 days from the receipt of the claim. Processing means paid or denied.

All payments will be made based on the approved fee schedule in effect at the time service is delivered.

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Overpayment

Overpayments may be offset against future claims payments. In such cases, the facility will be notified of the action and given 30 days to appeal. Appeals should be submitted as described in the Procedure for Submitting County Funded SNF Appeals section of this handbook.

If a facility chooses to return excess funds by check, the check must be made payable to "County of San Diego" and mailed to Optum Public Sector San Diego/ Claims Department for processing at the address below:

Optum Public Sector San Diego/ SNF
Claims/Refunds
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

How to Submit Billing Inquiries

Facilities may submit specific questions regarding claims to Optum Public Sector San Diego via phone or facsimile.

Facilities may call (800) 798-2254, Option 2 for all claims related inquiries. Facilities may also submit questions via facsimile to (619) 641-6975.

Written inquiries may be sent to:

Optum Public Sector San Diego/ SNF
Claims Services
P.O. Box 601340
San Diego, CA 92160-1340

Claims Problem Resolution and Appeals

In the event of a denied claim, a facility may appeal the decision by contacting the Claims Provider Service Representative at (800) 798-2254, Option 2. The Senior Claims Examiner will contact the SNF to resolve the appeal informally. The SNF provider may be asked to submit written documentation justifying the request to overturn the denial.

Should the outcome of the informal problem resolution process result in a decision that the facility feels is not satisfactory, the facility may submit a formal claims appeal, in writing, with supporting documentation to:

Optum Public Sector San Diego
Attn: Claims Provider Services
P.O. Box 601340
San Diego, CA 92160-1340

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Acknowledgment of written appeals will be mailed to the facility within two (2) business days of receipt. Supporting documentation must include the client name, Medi-Cal BIC Number, date(s) of service and authorization number with supporting documentation available. A written response will be sent to the facility within 30 days of receipt of the claims appeal.

Ethical, Legal and Billing Issues Hotline

The County of San Diego has created a hotline to report concerns about a variety of ethical, legal, and billing issues. The confidential hotline is toll-free and available 24-hours per day, seven (7) days per week. Callers may remain anonymous, if they wish. Providers are encouraged to contact the hotline with any concerns regarding misconduct, fraud or abuse. The number of the County of San Diego's Mental Health Plan Compliance Hotline is (866) 549-0004.

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Serious Incident Reports (SIR)

SNF providers are required to report unusual occurrences or "serious incidents" involving clients in active treatment to San Diego County Behavioral Health Services (BHS), in accordance with policies and procedures established by the County. A copy of the *Serious Incident Report form* is located on the Optum Public Sector San Diego website, SNF section. For assistance in completing a Serious Incident Report, please contact Provider Services at (800) 798-2254, Option 7.

Serious incidents are those that result in death or serious physical injury to a client on the program's premises. The event is associated with a significant adverse deviation from the usual process in providing behavioral health care. A Level One Serious Incident has the potential to be reported in the media or significant adverse media involvement. Examples of Serious Incidents include death of a client, serious suicide attempt by client; homicide attempt by or towards a client; adverse reaction to medication resulting in loss of consciousness or difficulties requiring hospitalization.

Level One Serious incidents should be reported to the County immediately. Providers are required to fax the Level Two (2) Sir within 72 hours of the occurrence, using the confidential *Serious Incident Report (SIR)* located on the Optum Public Sector San Diego website, SNF section. This report should be faxed to the County of San Diego Behavioral Health Services (BHS) at (619) 236-1953. Questions regarding the reporting of serious incidents may be directed to Optum Quality Improvement at (619) 563-2747.

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Complaints about Administrative and Contract Issues

Complaints about Optum Public Sector administrative procedures, referral authorizations, forms, response or lack of response by an Optum Public Sector employee, as well as other general questions and concerns about policies and procedures, can be discussed with any Optum Public Sector staff person with whom the provider comes in contact. Optum Public Sector documents the content of the complaint and is obligated to come to a resolution within 30 days of receiving the complaint. The participation of providers in this process is viewed as a reflection of the providers' genuine commitment to improve the quality of care and service. Providers are protected from any form of retaliation because of filing a complaint. Optum Public Sector tracks and trends the data gathered from complaints and appeals and uses this information to focus quality improvement initiatives.

Providers may present complaints, issues, or concerns to Optum Public Sector by contacting the Provider Line at (800) 798-2254, Option 7, or by calling the County Mental Health Plan QI Department at (619) 563-2713.

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