



**L.A. Care**  
HEALTH PLAN®

# **Long Term Care (LTC) Nursing Facility Resource Guide**

**January 2015**

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## Section 1: Introduction and Overview

### Introduction

With pleasure we welcome you as a contracted provider (“provider”) for L.A. Care Health Plan. We appreciate your participation in helping us fulfill our mission to provide quality and affordable healthcare for the well-being of our members.

This resource guide was created to help guide you and your staff in working with L.A. Care Health Plan. The intent is to ensure that your relationship with us works well for you, your staff and your L. A. Care members.

### **Purpose and Organization of the *Long Term Care Nursing Facility Resource Guide***

The *Long Term Care Nursing Facility Resource Guide* is intended to assist you with understanding the administrative processes related to providing facility-based long term care to L. A. Care members. L.A. Care’s goal is to make this guide as helpful as possible. This guide supplements, and does not replace or supersede, the Agreement between you and L.A. Care. Updates to the *Long Term Care Nursing Facility Resource Guide* will be made on a periodic basis in accordance with the Agreement and in response to changes in operational systems and regulatory requirements. In the event of any discrepancy between the terms of the *Long Term Care Nursing Facility Resource Guide* and the Agreement, the terms of the Agreement will govern.

The purpose of the guide is to provide information and resources that will be useful in coordinating services for L.A. Care members. It provides detailed instructions for obtaining authorizations and receiving payment for long term care Nursing Facility services. The contents of the *Long Term Care Nursing Facility Resource Guide* have been organized according to similar topics and functions. Please refer to the complete table of contents at the beginning of this guide, which includes headings for topics within each section.

Your satisfaction with L.A. Care is vital to our relationship. We welcome and encourage your comments and suggestions about this guide or any other aspect of your relationship with L.A. Care. For clarification, questions or comments about your role as a Provider for L.A. Care, please call upon Provider Relations at (866) 522-2736, press #3.

## About L.A. Care Health Plan

Implemented in October 1, 1995, L.A. Care's innovative managed care program is the result of a long-standing community effort to improve access to health services for Los Angeles County's low-income populations. L.A. Care is a public agency that manages the financing and delivery of health care services to Medi-Cal and Medicare eligible residents of Los Angeles County.

L.A. Care is governed by a 13-member Board of Governors. Eleven Regional Community Advisory Committees (RCAC's) comprised of L.A. Care members, health care providers and other stakeholders, who advise L.A. Care on key issues.

## L.A. Care's Model of Care

Nursing Facilities play an important role in ongoing support for frail and disabled members.

Nursing Facility Services are provided by certified nursing homes, which primarily provide three types of services:

- **Skilled nursing** - required for the treatment of medical conditions;
- **Rehabilitation** - required to restore functional abilities due to injury, disability, or illness;
- **Long term care** - required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care the LTC benefit for these services includes room and board and other covered services medically necessary for care.

L.A. Care's long term care Nursing Facility provider network includes Los Angeles Medi-Cal licensed and certified Nursing Facilities - Level B, also known as Skilled Nursing Facilities (SNFs).

For L.A. Care members residing in a Nursing Facility, L.A. Care contracts with physicians to serve as the primary care physician. A physician may be supported by nurse practitioners and physician assistants to manage the care of our members. In addition to physician oversight, L.A. Care has dedicated care managers with extensive experience in managing care in a Nursing Facility, who are assigned to address continued authorization and care coordination needs. Care managers (usually a RN) work to ensure that L.A. Care members have the appropriate level of care and timely access to covered benefits and community resources.

L.A. Care's Managed Long-Term Services and Supports (MLTSS) Department administers programs targeted at helping individuals remain living independently in the community. In addition, the MTLSS Long Term Care program provides long term care services to manage Nursing Facility admissions and assist members who may wish to transition from the Nursing Facility to the community setting.

## L. A. Care Administrative Offices and Key Contacts

1055 West 7th Street, 10th Floor  
Los Angeles, CA 90017  
Phone: (213) 694-1250  
[www.lacare.org](http://www.lacare.org)

### Authorizations

- Nursing Facility  
(Long Term Care) (855) 427-1223  
[LTSS@lacare.org](mailto:LTSS@lacare.org)  
Fax: (213) 438-4877
- Nursing Facility/  
Sub-acute (Skilled) (877) 431-2273

### Claims

(866) 522-2736, press #2  
L.A. Care Claims Department  
P.O. Box 811580  
Los Angeles, CA 90081

### Managed Long-Term Services and Supports

(855) 427-1223  
Fax: (213) 438-4877  
E-Mail: [LTSS@lacare.org](mailto:LTSS@lacare.org)

### Medical Management

- Care Management Department
  - Utilization Management Department
- (877) 431-2273  
Fax: (877) 314-4957

### Member Services

(888) 839-9909

### Provider Relations

(866) 522-2736, press #3  
[Providerrelations@lacare.org](mailto:Providerrelations@lacare.org)

### Telephonic Interpreters

- Providers (888) 930-3031
- Pharmacies (888) 942-7670

### Transportation

(Non-emergency, medically necessary)

- English (866) 529-2141
- Spanish (866) 529-2142

## Section 2: Member Eligibility Verification

### Tools for Verifying Member Eligibility

Verifying member eligibility is essential to successfully coordinating and receiving payment for covered services. This section provides information and guidelines about how to verify L.A. Care eligibility, what to watch for, and how changes could affect payment.

#### **Determining eligibility**

L.A. Care does not determine Medi-Cal eligibility. Medi-Cal eligibility and assignment to L.A. Care is determined by the State of California Department of Social Services. For questions about a particular L.A. Care member's eligibility, call L.A. Care's Provider Information Line at 1-866-LA-CARE6 (1-866-522-2736) to be connected to L.A. Care's automated eligibility system or a representative. However, the most current information is found by accessing the State of California's eligibility verification systems.

Providers may also verify Medi-Cal eligibility through the L.A. Care Provider Portal. The site lists member assignment of Independent Practice Association (IPA), primary care physician and capitated hospital, as applicable. You may request Login Setup from your assigned Account Specialist or e-mail [Providerrelations@lacare.org](mailto:Providerrelations@lacare.org). You will be asked to provide your organization's name and address, as well as a list of individuals requiring access (full name, title, e-mail and phone number). You will receive an e-mail with user name, password and a link to activate the account.

***It is important to check eligibility each time a member is accessing services.***

#### **Medi-Cal and L.A. Care ID cards**

The State of California provides a Benefits Identification Card (BIC) to each Medi-Cal beneficiary. In addition, all L.A. Care members have an L.A. Care identification card. L.A. Care's Plan Partners also issue their members a separate member I.D. card. However, a member's possession of L.A. Care membership card does not guarantee current membership with L.A. Care or with the Participating Physician Group (PPG) identified in the card.

#### **Accessing the Medi-Cal Beneficiary Eligibility Verification System**

To verify member eligibility and health plan enrollment, providers must access the State of California's Medi-Cal Beneficiary Eligibility Verification System. This system includes:

- Point of Service (POS) Device
  - To inquire about purchasing a POS Device, please call the POS Help Desk at (800) 427-1295, press #3 for assistance and remain on the line
- Automated Eligibility Verification System (AEVS) at (800) 456-2387 (see below).

**Website:** <https://www.medi-cal.ca.gov/Eligibility/EligResp.asp>

## Eligibility Response



Name:		
Subscriber ID:		
Service Date: <b>07/01/2014</b>	Subscriber Birth Date:	Issue Date: <b>07/21/2014</b>
Primary Aid Code: <b>63</b>	First Special Aid Code:	
Second Special Aid Code: <b>80</b>	Third Special Aid Code:	
Subscriber County: <b>19 - Los Angeles</b>	HIC Number:	
Primary Care Physician Phone #:	Service Type: <b>R</b>	
Spend Down Amount Obligation: <b>\$886.00</b>	Remaining Spend Down Amount:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: <b>SUBSCRIBER LAST NAME: _____ . CNTY CODE: 19. PRMY AID CODE: 63. 2ND SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ LTC SOC/SPEND DOWN OF \$00886. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP _____ PART A, B AND D MEDICARE COV. MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: CO. COV: R.</b>		

Nursing facilities must have a Personal Identification Number (PIN) to access eligibility systems. LTC facilities are given a PIN when they become certified Medi-Cal providers. If you do not have a PIN, please contact the Fiscal Intermediary (FI) Telephone Service Center at (800) 541-5555, press #3 for assistance and remain on the line.

**POS** and **AEVS** will inform the facility:

- If the resident is eligible for Medi-Cal benefits on the date of service
- If the resident is a member of L.A. Care
- If the resident is enrolled in a L.A. Care health network



- The telephone number of the resident’s health network if the resident is enrolled in a health network
- The resident’s primary care physician (PCP) information if the member is in a health network
- If the resident has a Share of Cost (SOC) or a LTC SOC
- If the resident’s SOC or LTC SOC has been met.

**Non-L.A. Care members with Medi-Cal**

If the AEVS shows eligibility for the date of service, but does not identify the resident as a L.A. Care member, L.A. Care is not responsible for the resident’s care.

**Obtaining an eligibility printout**

Checking eligibility through the POS device will enable the facility to obtain a printout detailing member eligibility information for the date of service. This printout can be used for documentation should a discrepancy arise regarding a resident’s eligibility. It is highly recommended that this printout be maintained in the resident’s file.

**Medical, ancillary and acute care services**

If the member is enrolled in an L.A. Care health network, the member’s primary care physician is responsible for arranging for provision of covered medical care services. In most health networks, the member must be referred by the PCP for services in order to receive reimbursement for services rendered (with the exception of emergency or family planning services).

**Members with Medi-Cal Share of Cost**

Some L.A. Care beneficiaries qualify for their Medi-Cal benefit with a monthly share of cost (SOC). Such members must meet a specified share of cost for their medical care expenses before they can be certified to receive Medi-Cal or L.A. Care benefits. This monthly share of cost is based on the member’s monthly income. When a Medi-Cal beneficiary has an LTC aid code and a SOC, a Nursing Facility will subtract the SOC that is paid or obligated to be paid from the claim amount. L.A. Care will pay the balance.

L.A. Care assumes Nursing Facility residents in long term care will meet the share of cost on a monthly basis and are therefore presumed eligible at the beginning of each month. If a Nursing Facility has questions about a SOC and potential balance billing of the member, please check AEVS BEFORE billing the member.

Under the *Johnson vs. Rank* settlement, recipients may use their share of cost to pay for necessary, non-covered medical services, remedial services or items not covered under the Medi-Cal program. A “medical service” is considered a non-covered benefit if either of the follow is true:

- 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 must be submitted and approved before Medi-Cal will pay and either an authorization request is not submitted, or an authorization request is submitted and denied because the service is not considered medically necessary.

A current physician's order is necessary for medical services and must be put in the recipient's medical record at the facility. The order must be a part of the physician's plan of care. After a copy of the order and the bill is presented to the facility, the facility will deduct the cost from that month's share of cost and bill L.A. Care for the remaining balance. If you have any questions about the share of cost process, please contact L.A. Care's MLTSS Department at (855) 427-1223.

## Section 3: Authorization Process

### Introduction to Authorization

*Obtain authorization each time a member is accessing services.*

#### **Sub-acute or Skilled Care**

L.A. Care's Medical Management (MM) Department or a L.A. Care delegated Participating Physician Group's Utilization Management Department is responsible for authorization of skilled care services. Please see L.A. Care's Provider Manual for admission instructions or contact L.A. Care at (877) 431-2273.

#### **Long Term Care**

L.A. Care's Managed Long-Term Services and Supports (MLTSS) Department is responsible for the management and authorization of services for long term care admissions in nursing facilities. Authorization for admission is processed in accordance with the following L.A. Care guidelines:

- The LTC Referral Request Form (RRF) replaces the California Department of Health Care Services (DHCS) Treatment Authorization Request (TAR) 20-1 form. For a copy of the LTC RRF contact L.A. Care's MLTSS Department at (855) 427-1223 or obtain a copy on-line at <http://www.lacare.org/provider-forms> under Long Term Services and Supports.
- The MLTSS Department uses DHCS Medi-Cal skilled nursing criteria to determine appropriateness of admissions and continued stay (Title 22 §51335 and §51003).

### Continuity of Care

Effective April 1, 2014, California's Coordinated Care Initiative (CCI) transitioned the Medi-Cal long term benefit to a managed care benefit.

- A beneficiary who is a long term resident of a Nursing Facility prior to enrollment in CCI will not be required to change Nursing Facilities if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and L.A. Care agree to appropriate rates.
- For Nursing Facilities with residents who are assigned to L.A. Care, existing approved DHCS TARs will be honored for the initial authorization and used to create a L.A. Care authorization, which is valid for a six month period from the date of enrollment.

## **Authorization of Medicare and Medi-Cal Services**

L.A. Care authorizes Nursing Facility services for members when medically necessary. Applicable levels of care are maintained and consistent with policies established by the Centers for Medicare and Medicaid Services (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22 CCR §51003.

## **Initial LTC Authorization and Reauthorization Process**

LTC RRF correspondence and communication should be submitted to:

L.A. Care Health Plan  
Attn: LTC Referral  
MLTSS Department  
1055 West 7<sup>th</sup> Street, 10<sup>th</sup> Floor  
Los Angeles, CA 90017  
(855) 427-1223  
[LTSS@lacare.org](mailto:LTSS@lacare.org)  
Fax: (213) 438-4877

The L.A. Care LTC RRF may be used to initiate a Nursing Facility authorization and reauthorizations when:

- A L.A. Care member is a new admission to the nursing facility.
- The member has exhausted Medicare benefits and will remain in the Nursing Facility for continued skilled care.
- Medicare benefits have been denied.
- The member has been readmitted from an acute care hospital and (did not return on day number eight).
- The member has returned from an approved leave of absence but the return date is beyond the approved time period allowed.
- A resident becomes an L.A. Care member while residing in the facility, as either a new Medi-Cal beneficiary or an existing Medi-Cal beneficiary, whose county of eligibility has changed (from another county to Los Angeles County and is an L.A. Care member).

Authorizations and reauthorizations for long term care admissions are valid for up to two years. Authorization numbers should be retained and submitted on the nursing facility's claims.

### ***Initial authorization***

Nursing Facilities must submit appropriate documentation to support the Nursing Facility admission. See a sample LTC Referral Request Form below.



Submit

Print

### Long Term Care Referral Request Form

Resources other than LTC offered and explored prior to LTC referral?  Yes  No

Please check all that apply:  In-Home Supportive Services (IHSS)  Community Based Adult Services (CBAS)

Multipurpose Senior Services Program (MSSP)

Home and Community-Based Services (HCBS)

Long Term Care/ Custodial Referral Request:

Date of Referral: \_\_\_\_\_

SNF

Sub-Acute (Vent)

Sub-Acute (Non-Vent)

Initial

Re-Authorization

Retroactive Eligibility

Start of Service Date \_\_\_\_\_

Bed Hold/Leave of Absence Bed Hold Start Date: \_\_\_\_\_

#### SECTION I

PROVIDER: Authorization does not guarantee payment. L.A. Care Eligibility must be verified at the time the services are rendered.

Patient Name: \_\_\_\_\_ Gender:  Male  Female D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

CIN: \_\_\_\_\_ Aid Code: \_\_\_\_\_ County Code: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Medicare Status:

Benefits NOT Exhausted

Number of Medicare Days Available: \_\_\_\_\_

L.A. Care D-SNP

Benefits Exhausted

Date Medicare Benefits Exhausted: \_\_\_\_\_

D-SNP Other

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone #: \_\_\_\_\_ Facility Fax #: \_\_\_\_\_

Facility Contact: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone#: \_\_\_\_\_ Physician Fax#: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 Code/s: \_\_\_\_\_

#### SECTION II

Admitted From:

- Home
- Board & Care
- Acute Hospital
- Emergency Room
- Another SNF
- Other

#### SECTION III

Date of LTC Placement Referral: \_\_\_\_\_

Community Options Available:  Yes  No

Type of Options: \_\_\_\_\_

Reason for LTC SNF Placement: \_\_\_\_\_

#### SECTION IV

Patient's General Condition:

- Bedridden
- Ambulatory  Ambulatory with Assistance
- Wheelchair Confined
- Incontinent of B&B
- Maximum Assist with all ADLs
- Other \_\_\_\_\_

#### SECTION V

Referring Person Name: \_\_\_\_\_

Relationship or Title \_\_\_\_\_

Phone Number: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Documentation should include:

- Verification of L.A. Care eligibility
- Completed LTC RRF and physician order with physician signature
- Documentation to support the level of care requested, i.e. Interdisciplinary Team Evaluation, MDS 3.0, etc.

The LTC RRF must be submitted to L.A. Care MLTSS Department within 21 calendar days of member's admission. The L.A. Care LTC Nurse Specialist will notify the facility of the RRF decision within regulatory requirement defined in L.A. Care policies. If the member meets admission criteria, the LTC Nurse Specialist will contact the Nursing Facility with the assigned authorization number. If the member does not meet the admission criteria, the Nursing Facility will receive a denial notification and will not be paid from the date of the admission.

Nursing Facilities are responsible for notifying the LTC Nurse Specialist if the 21 day limit expires. If the RRF is not submitted to L.A. Care within 21 calendar days of the admission, the Nursing Facility is subject to denial or reduction of payment for days beyond the 21<sup>st</sup> day of admission.

### **Reauthorization**

For reauthorization, documentation should include:

- Verification of L.A. Care eligibility
- Completed LTC RRF and physician order with physician's signature
- Documentation to support the level of care requested, i.e., Interdisciplinary Team Evaluation, MDS 3.0, etc.

A reauthorization request must be submitted to the L.A. Care MLTSS Department prior to the expiration date of the active RRF (and up to 60 days prior to the active RRF expiration date.) The RRF for reauthorization request must be submitted to L.A. Care MLTSS Department prior to the expiration date of the active RRF (and up to 30 days prior to the active authorization expiration dates.) The L.A. Care LTC Nurse Specialist will notify the facility within five business days (or 72 hours for urgent requests) of the RRF decision within regulatory requirements and as defined by L.A. Care policies. If the member meets continued stay criteria, the LTC Nurse Specialist will contact the Nursing Facility with the assigned authorization number. If the member does not meet the continued stay criteria, the Nursing Facility will receive a denial notification and will not be paid from the date of the admission.

Nursing Facilities are responsible for notifying the LTC Nurse Specialist before the RRF expires. If the RRF is not submitted to L.A. Care prior to the expiration, the Nursing Facility is subject to denial or reduction of payment for days beyond the expiration date.

## **Changes in a Member's Condition and Discharge**

A Nursing Facility may modify its care of a member or discharge the member if the Nursing Facility determines that the following specified circumstances are present:

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

L.A. Care requires documentation from the Nursing Facility to verify that the facility's care modification was made for the allowable reasons noted above. When these circumstances are present, L.A. Care shall arrange and coordinate a discharge of the member and continue to pay the Nursing Facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate care setting.

L.A. Care will also arrange and coordinate the discharge of a member if L.A. Care determines that one, or more of the three circumstances noted above are present, or if the facility does not meet L.A. Care's network standards because of documented quality of care concerns.

## **Member's Transition to Skilled Care**

If a LTC resident has a change in health status and requires skilled care services, the Nursing Facility must notify the assigned LTC Nurse Specialist of the transition of care within 24 hours or by the next business day. Nursing facilities must not withhold medically necessary services pending L.A. Care's authorization when the services are requested by a designated physician, or health care professional in lieu of emergency room transfers or acute care admissions. L.A. Care or its delegate will provide post-service authorization for medically necessary services provided to members.

## **Bed Hold and Leave of Absence**

L.A. Care provides, as a covered benefit, any bed hold or leave of absence that a Nursing Facility provides in accordance with the requirements of Title 22 California Code of Regulations, §72520.

### ***Bed hold guidelines***

Bed hold requests are required when a member's stay is being covered by Medicare or a Medicare health plan and the member is admitted to an acute care hospital with an anticipated length of stay of not greater than seven (7) days.

Nursing Facilities are required to hold a bed vacant when requested by the member or member's responsible party, unless notified that the member requires more than seven days of acute hospitalization. A physician's order for hospitalization and bed hold must be in place. The member must be in the facility at least 24 hours prior to start of the bed hold. If the LTC Nursing Facility is aware that the member requires greater than seven days of acute hospitalization, the facility is not required to hold the bed and cannot bill L.A. Care for any remaining bed hold days. Bed hold payments will not be made when a member is discharged from the facility that is receiving payment for a bed hold within 24 hours from his or her return from an acute care hospital. Bed hold payment terminates on the member's day of death.

For dually eligible beneficiaries not currently enrolled in Cal MediConnect who are receiving skilled care under Medicare Fee for Service, L.A. Care will pay for eligible bed-hold days as described in this guide under the *Bed Hold and Leave of Absence* section.

There are no limits to the number of bed hold episodes. However, the member must remain at the facility for at least 24 hours prior to the start of the next bed hold period. The date of departure counts as day one of the bed hold. The day of return will be counted as a day of acute care. The member is considered discharged if not returned to the facility on day eight after an acute care hospital admission.

A completed LTC RRF marked "bed hold" must be submitted within 21 days of the final day of the bed hold or before submitting a claim for reimbursement. L.A. Care will issue a response within five business days of receipt of a completed request.

### ***Leave of absence guidelines***

In addition to acute hospitalization bed holds, up to 18 days leave of absence may be prescribed by a PCP for a visit with relatives or friends and outpatient diagnostic or treatment services at an acute hospital. Twelve days of leave per year may also be approved for the physical and mental well-being of a member. A provision for the leave of absence including dates, intended destination and reason for the leave must be documented in the member's plan of care.

The request for a leave of absence must be submitted on a LTC RRF marked "leave of absence" two weeks prior to the leave. L.A. Care will issue a response within five business days of receipt of a completed request. If a member voluntarily leaves the facility without an approved leave of absence request or fails to return by midnight on the scheduled date of return, the member is considered "AWOL" and a new LTC RRF is required, when the member returns.



## Section 4: Claims and Payment

### Claims Submission

Long term care providers rendering services to L.A. Care members must follow all Medicare and /or Medi-Cal rules and regulations for billing. Claims may be submitted electronically or by mail.

Mail a paper claim to:

L.A. Care Health Plan  
Attn: Claims Department  
P.O. Box 811580  
Los Angeles, CA 90081

Electronic claims are accepted via *officeally.com*, *mdxnet.com* or *ssimed.com*. The payer identification is LACAR. Enable electronic claim submission by faxing a W-9 form to L.A. Care's Provider Data Unit at (213) 438-5081, Attn: Electronic Claims Activation.

L.A. Care must have a contract or Memorandum of Understanding (MOU) and a facility W-9 on file to process claims. If the facility is not contracted with L.A. Care, you must engage L.A. Care to execute a contract or member-specific MOU. To begin the process, e-mail a letter of interest and W-9 to Gwen Cathey at [Gcathey@lacare.org](mailto:Gcathey@lacare.org).

For questions about submitting a claim, call the Claims Department at (866) 522-2736, press #2.

### Claims Billing Process

Long term care providers rendering services to L.A. Care members must submit claims using the Institutional Provider Claim Form (UB-04). When submitting a claim, please be sure to include all required data elements in order to assure timely payment. To be processed, an authorization number must be included on the claim form and the claim must match the authorization. An initial claim submission must occur within six months from the date of service. Providers should follow all Medicare and /or Medi-Cal rules and for billing. A copy of the UB-04 with instructions may be downloaded from the CMS website at:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf>

For additional information, please refer to L.A. Care's Skilled Nursing Facility (SNF) *Claims Quick Reference Guide* located at <http://www.lacare.org/providers/claims-and-icd-10/submitting-claim>.

## **Medicare Co-Insurance and Deductibles**

L.A. Care covers Nursing Facility Medicare co-insurance and deductibles. L.A. Care does not require member's to pay co-insurance or deductibles for Nursing Facility services.

Questions about co-insurance or deductibles related to Nursing Facility services should be directed to L.A. Care's Claim Department at (866) 522-2736, press #2.

## **Claims Processing**

L.A. Care pays claims in accordance with regulatory timeliness guidelines. Clean claims will be paid within 30 calendar days from the date of receipt. If your claims are paid, denied, contested or adjusted L.A. Care will provide a clear and accurate written explanation of the specific reasons for the claim determination.

If your claim is submitted with incomplete information, or if L.A. Care requires additional information, L.A. Care will notify you in writing of the additional information needed. Upon receipt of the additional information, L.A. Care will pay, deny or adjust the claim within 30 calendar days from the date the additional information was received by L.A. Care in order to review and process your claim. Interest will be paid on all late claims as mandated by State law. If the Nursing Facility does not agree with the decision, the Nursing Facility may "dispute" the claim determination. A full description of the Provider Dispute Resolution process is defined in Section 5, *Complaint Process*, included in this guide.

Should billing discrepancies occur, L.A. Care will try to make every attempt to resolve the discrepancy in a timely manner. L.A. Care may require copies of medical records or other relevant information in order to resolve any discrepancies.

For further assistance on how to submit a claim or the Provider Dispute Resolution process, contact us at (866) 522-2736, press #3.

## **Corrected Claims**

If a claim is denied and the Nursing Facility is able to provide additional information to support payment, the Nursing Facility may resubmit the claim with the additional information within 365 days from the last action date of the claim.

## **Claims Issues**

If you have questions about the claim submission process or billing codes, you may contact L.A. Care's Claims Department at (866) 522-2736, press #2, or the MLTSS Department for assistance.

If claims are denied or modified and the Nursing Facility does not agree with (disputes) the claim decision, the Nursing Facility may submit a “provider dispute” to request that L.A. Care reconsider the claim determination. A provider has 365 days from the last action date on the claim to submit the Provider Dispute Resolution (PDR) request form requesting review and reconsideration of the claim. To dispute a claim, the Nursing Facility must submit the PDR request form with a copy of the claim, authorization and reason for the dispute. L.A. Care has 45 business days from the receipt date of the PDR request form to respond to a dispute. Please see Section 5, *Complaint Process*, below for additional information.

## **Payment**

L.A. Care is required to reimburse institutional providers in accordance with the prompt payment provisions provided by DHCS, including the ability to accept and pay electronic claims.

As a reminder, upon entering into a contract with L.A. Care to provide services for L.A. Care members, **all providers agree to accept L.A. Care payment(s) as payment in full** with no right to seek additional payments from members. For payment of non-authorized services where the member is deemed responsible, as determined by L.A. Care policy and procedures, L.A. Care staff will speak to the member and/or family regarding payment.

## **L.A. Care’s Electronic Fund Transfer**

At the time of the publishing of this document, L.A. Care has developed a process for EFT. For a full description of accessing the EFT process, please contact L.A. Care’s Provider Relations at (866) 522-2736, press #3 or [Providerrelations@lacare.org](mailto:Providerrelations@lacare.org).

## **Reporting Fraud, Waste and Abuse (FWA)**

Claims for which L.A. Care establishes reasonable grounds for suspicion of possible fraud, misrepresentation or unfair billing practices will be forwarded to the L.A. Care’s Fraud, Waste and Abuse Department, Compliance Officer and/or other outside agencies for review.

Nursing facilities that identify or wish to report potential issues related to Medicare or Medi-Cal fraud, waste or abuse may contact L.A. Care 24 hours a day/7 days a week/365 days per year. The FWA hotline number is (800) 400-4889.

## Section 5: Complaint Process

Long term care facilities may request a reconsideration of an L.A. Care decision using the appeal process on behalf of the member or the Provider Dispute Resolution (PDR) process.

### L.A. Care's Levels of Complaint Processing

L.A. Care maintains various ways to submit a complaint or concern. These include:

- Member Grievances, or grievances filed on behalf of the member
- Member Appeals, or provider's appealing on behalf of the member
- Provider Complaints Resolution (administrative/contract issues)
- Provider Dispute Resolution (payment/claims related).

Complaints relating to member's care are determined by the member or the member's physician and based on the urgency of the service. The two timeframe categories are:

- Expedited (Urgent) – processing within 72 hours from the receipt
- Standard (Routine) – processing within 30 calendar days from the receipt.

Complaints related to administrative, contractual or claims processing are not considered urgent and will be resolved within 30 calendar days from receipt of the request.

### Member Grievances

Member grievances are defined as any expression (oral or written) of dissatisfaction related to care and/or services provided to a member. This includes any complaint, dispute, requests for reconsideration or appeal made by a member. Member grievances from the member, member's family or Nursing Facility on behalf of member should be directed to L.A. Care's Member Services Department at (888) 839-9909. Or fax or mail the grievance to:

L.A. Care Health Plan  
Attn: Grievance and Appeals Department  
P.O. Box 811610  
Los Angeles, CA 90081  
Fax: (213) 438-5748

### Member Appeals

For authorization of service requests received and the determination made to deny or modify the request, the member/member's representative, primary care physician and

requesting provider will receive written communication of the determination, or Notice of Action (NOA). Upon receipt of a NOA, the member/member's representative or Nursing Facility **on behalf of the member** may request reconsideration (appeal) of a level of care decision to deny or modify a request for services. Appeals must be submitted in writing to L.A. Care within 90 calendar days from the date of the Notice of Action and include:

- A letter clearly stating the request
- Relevant material such as clinical documentation
- A copy of the NOA received.

Fax the appeal to:

L.A. Care Health Plan  
Attn: Grievance and Appeals Department  
P.O. Box 811610  
Los Angeles, CA 90081  
Fax: (213) 438-5748

## **Grievance and Appeals Process**

L.A. Care will acknowledge receipt of the complaint within five business days. L.A. Care's Grievance and Appeals Department will review the request. The Grievance and Appeals Nurse Specialist will prepare documents for review with an L.A. Care's Medical Director who was not involved in the initial decision or the department involved in the decision. If the information provided in the written complaint is not adequate, a L.A. Care Grievance and Appeals representative will request missing or additional information in writing. All of the complaints will be resolved, for routine complaints within 30 calendar days and 72 hours for urgent, from the date of receipt. Details of the resolution, including the date the resolution will be/has been implemented, are communicated in writing to the member and the provider. If resolution of the complaint is anticipated to exceed 30 calendar days from the date of receipt, because of the need for a detailed investigation, this delay and anticipated date for resolution will be communicated in writing to the member and the provider.

## **Provider Complaint Resolution**

L.A. Care will make every effort to assist you in the resolution of complaints or problems encountered while providing services to L.A. Care members. Complaints must be filed within 365 calendar days of L.A. Care action, or in the case of inaction that is less than 365 days, after the most recent time for contesting or denying claims has expired.

For assistance in resolving administrative or contractual complaints or problems related to member care, please contact L.A. Care's Provider Relations at (866) 522-2736, press #3 or [Providerrelations@lacare.org](mailto:Providerrelations@lacare.org). The L.A. Care Provider Relations staff will confer with

other departments as necessary to respond to your complaint. Provider Relations' staff will be able to answer most questions and resolve your concern immediately.

For a grievance, complaint or appeal related to medical necessity, you must first file an appeal as described above.

For administrative issues (or if dissatisfied with the appeal decision of a denial related to medical necessity) you may file a provider complaint. Examples of administrative issues include clarification of authorization process, billing process or provider issues. Any question or concern that suggests issues that are not administrative in nature will be routed to the appropriate department for review. Clinical issues will be forwarded to the MLTSS Department and potential quality of care issues will be forwarded to the Grievance and Appeals Department for review by a clinical staff person.

For issues related to claims, you must first follow the claims Provider Dispute Resolution process outlined below. If you are dissatisfied with the claims resubmission decision or denial, a complaint may be filed.

When making a complaint, please make sure to include the following:

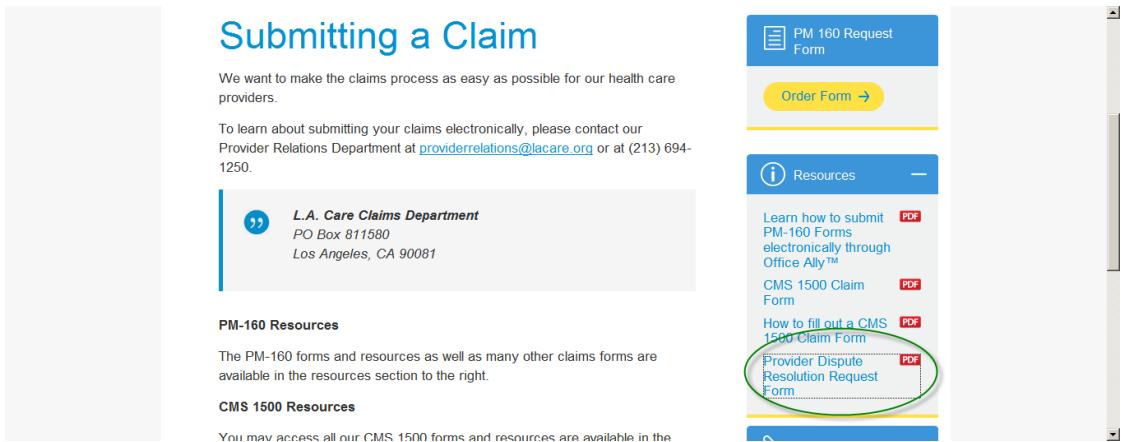
- Provider's name and identification number (i.e., NPI)
- Provider's contact information, including: address, telephone number and fax number of the provider's contact person
- An explanation of the complaint or issue, including: any relevant attachments, documentation, and supplemental information

If the complaint involves a service provided to L.A. Care member, please include: the member's name, member's identification number, and date of service.

## **Provider Dispute Resolution**

If a Nursing Facility claim is denied or modified and it does not agree (disputes) with the claim decision, Nursing Facilities may submit a "provider dispute" to request that L.A. Care reconsider the determination. The L.A. Care Claims Department will be able to assist with starting a formal appeal or a Nursing Facility may download a copy of the PDR form by going to L.A. Care's website at:

**Website:** [http://www.lacare.org/sites/default/files/provider\\_dispute\\_form.pdf](http://www.lacare.org/sites/default/files/provider_dispute_form.pdf).



Mail or fax the PDR to:

L.A. Care Health Plan  
Attn: L.A. Care's Claims Department/  
Provider Dispute Resolution Unit  
P.O. Box 811610  
Los Angeles, CA 90081  
Fax: (213) 438-5057

L.A. Care will acknowledge receipt of the provider dispute within 15 business days. L.A. Care's Claim Department/Provider Dispute Resolution Unit will review the request. A PDR Specialist will prepare document for review using contract and regulatory requirements. For PDRs based on denial due to the lack of medical necessity, the dispute will be reviewed with a health care professional or L.A. Care's Medical Director who was not involved in the initial decision, or the department involved in the decision.

A provider dispute must contain a clear identification of the disputed item, including the date of service, the name and identification number(s) of the member and a clear explanation of the basis upon which the provider believes the payment or action is incorrect. Be sure to include the same number assigned to the original claim. L.A. Care may return any provider dispute lacking the information listed above.

If the information provided in the written complaint is not adequate, a L.A. Care representative will request missing or additional information in writing. All disputes will be resolved within 45 business days from the date of receipt. Details of the resolution are communicated in writing to the provider.

## **Conclusion**

We hope that you have found the information and resources in this guide to be useful and helpful. If you have additional questions about any aspect of your relationship as a provider for L.A. Care, we encourage you to call Provider Relations at (213) 694-1250, extension 4719. We look forward to continued partnership with you to provide quality and affordable healthcare for the well-being of our members.