Optum

COUNTY OF SAN DIEGO Health and Human Services Agency

LIVE WELL SAN DIEGO

Skilled Nursing Facilities Handbook

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optumsandiego.com

Funding for services is provided by the County of San Diego Health and Human Services Agency

Table of Contents

Introduction

Optum Public Sector San Diego, hereinafter referred to as “Optum,” 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, 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 at optumsandiego.com > BHS Provider Resources > Long Term Care > Skilled Nursing Facilities.

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:

- Credentials and contracts with SNFs
- Authorizes County Funded SNF, SNF Patch, or NBU Patch, as part of Long Term Care (LTC) services
- Processes and pays claims for SNFs
- Conducts medical necessity and utilization management review for 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 use disorder support services, referrals and information for mental health
- Through the ACL, facilitates access to clinically appropriate, culturally competent services for San Diego County residents in need of mental health and/or substance use disorder services 24/7

Optum Provider Line can be reached at (800) 798-2254. In addition, the Optum website optumsandiego.com provides links to this handbook and helpful documents regarding SNF services.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Directory

Optum Contact Information		
Optum Claims • Billing questions	P: (800) 798-2254 Option 2 F: (877) 364-6945	E-mail for general claims information: psclaims@optum.com
Optum Public Sector San Diego Attn: Claims P.O. Box 601340 San Diego, CA 92160-1340	To submit: • County-funded SNF claims • Written inquiries regarding claims • Formal claims appeal with supporting documentation To return excess funds by check (Check must be made payable to "County of San Diego")	
Optum Utilization Management • Authorization for SNF services • Clinically related questions • General questions about County-funded SNFs or SNF Patch • Requests for authorization letters	P: (800) 798-2254 Option 3, then Option 5 F: (888) 687-2515 P: (800) 798-2254 Option 3, then Option 4 F: (888) 687-2515	Website: Long Term Care Optum San Diego
Optum Public Sector San Diego Attn: Utilization Management P.O. Box 601370 San Diego, CA 92160-1370		
Optum Provider Services • Contracting • Credentialing/Recredentialing • To update information	P: (800) 798-2254 Option 7 F: (877) 309-4862	E-mail: sdu_providerserviceshelp@optum.com
Optum Quality Improvement • Appeal questions • Administrative Day request questions	P: (619) 610-6736 F: (844) 897-5479	E-mail: sdqi@optum.com
Optum Quality Improvement Department P.O. Box 601370 San Diego, CA 92160-1370	To mail requests for: • Administrative Days Requests with supporting documentation • Appeal Requests with supporting documentation	
Important Contact Information		
Automated Eligibility Verification System (AEVS) (Must have valid PIN/User ID to access AEVS)	P: (800) 456-AEVS (2387) To obtain temporary PIN P: (800) 541-5555	Website: medi-cal.ca.gov
County of San Diego Mental Health Plan Compliance Hotline	P: (866) 549-0004	E-mail: compliance.hhsa@sdcounty.ca.gov
County Mental Health Plan QI Department	P: (619) 563-2713	Website: Technical Resource Library San Diego County

Contracting, Credentialing and Recredentialing Process

Optum, 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, 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 Optum 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 Contract (operating under the brand of Optum) was developed in conjunction with County Behavioral Health Services (BHS) and contains:

- The Facility Contract with general terms applicable to contractors delivering county services
- Services and rates with revenue codes and reimbursement schedules
- This handbook is included by reference in the Skilled Nursing Facility Contract

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

Credentialing

The Credentialing of SNF facilities is performed by a contracted Credentialing Verification Organization (CVO) for Optum Provider Services and includes documentation review and primary source verification. All SNFs are required to complete a Optum Credentialing and Recredentialing Application as part of the initial contracting process. The following documents are reviewed:

- Facility's State license
- Business license (if applicable)
- Medicare/Medi-Cal certification
- Commercial general liability
- Professional liability insurance/professional errors and omission liability insurance
- Claims made insurance
- Workers' Compensation
- Automobile insurance
- Sexual misconduct insurance
- Medicare/Medi-Cal Sanctions Report
- 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
- W9 and IRS Verification Letter

Recredentialing

Optum performs recredentialing of all SNF facilities. The recredentialing process occurs at a minimum of every thirty six (36) months from the most recent credentialing or recredentialing date. Optum will send an Optum Facility Credentialing and Recredentialing Application directly to the SNF to complete and return to them. This recredentialing process enables Optum to verify that the SNF continues to meet the credentialing criteria required to contract with Optum.

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
- Compliance with contract obligations and the Optum 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.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

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 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, whether a less restrictive setting is available and whether community resources such as self-help and peer support groups, consumer-run services, and preventive health programs can augment treatment.

- **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.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

SNF Guidelines for San Diego County Funding

Target population

1. Adults at least 18 years of age.
2. Clients with an adequately documented primary diagnosis of a serious, persistent, major mental disorder which requires treatment by licensed personnel in a secured mental health facility licensed as a Skilled Nursing Facility, in a 24-hour residential setting.
3. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court or signs a voluntary admission agreement.
4. Cannot be safely managed in a less restrictive level of care. All other alternatives including Augmented Services Board and Care, traditional Board and Care, Full Service Partnership case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's need.
5. Clients in an acute care psychiatric hospital requiring referral to a lower level of care, who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego and are not entitled to comparable services through other systems.

Client Services

Facility shall provide individualized services to clients such as:

1. Training to improve cognitive, behavioral, interpersonal coping skills.
2. Psychiatric symptom management.
3. Substance use recovery support focused on coping skills and relapse prevention skills.
4. Linkage to community-based organizations including, but not limited to, primary care clinics and complementary healing centers and organizations, faith-based congregations, cultural centers/organizations, and peer-directed programs such as Clubhouses.

Client services shall include the following:

1. Resolution or reduction of psychiatric symptoms or concerns.
2. Access to treatment and goals to stabilize psychiatric medication, including quarterly psychiatric visits with an MD/DO/PNP or PA trained in psychiatry.
3. Treatment of minor medical concerns as determined by a medical professional.
4. Education and support regarding activities of daily living, social skills, and dining.
5. Preparation for step-down to a lower level of care if clinically indicated.
6. Programming that may improve cognitive, behavioral, and interpersonal coping through groups, social events, and one on one staff support and interactions.
7. Access to recovery based meetings to address both mental health and substance use disorders.
8. Access to transportation to and from medical appointments or court hearings.
9. Facility supervised outings.

Specific requirements for service delivery:

1. Engage the client in developing a Care Plan.

2. Designate case management and/or social work staffing trained in cultural competencies and mental health care.

3. Program and services shall be trauma-informed and allow services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate consumer participation in services.

4. Upon admission to the program, the client shall be informed of their client rights as well as the rules and regulations of the program.

5. Each client shall receive an orientation of the facility at time of admission, personal supplies, and as appropriate, instructions to medication times, mealtimes, phone numbers to phones, activity schedule, visiting hours, a map of the facility, writing supplies, etc.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Utilization Management and Authorizations

Optum Public Sector San Diego Utilization Management

Optum Utilization Management (UM) Long Term Care (LTC) team is responsible for providing initial and continued stay authorizations for clients that meet San Diego County Funded Long Term Care Criteria as established by the County, for various levels of care, including County Funded Skilled Nursing Facility (SNF), SNF Patch, and Neuro Behavioral Unit (NBU) Patch. The criteria for various LTC levels of care may be found at optumsandiego.com > BHS Provider Resources > Long Term Care. County funded Long Term Care referrals are accepted from Lanterman-Petris-Short (LPS) - Designated Acute Care Psychiatric Hospitals. Written clinical information provided by the SNF or hospital to Optum is reviewed by Optum Care Advocates and an Optum Medical Director to determine whether admission and/or continued stay criteria is met. Authorization requests are accepted from SNFs for existing residents when the client's San Diego Medi-Cal Managed Care Plan (MCP) has denied authorization due to their determination that the client's medical needs do not warrant SNF placement. Authorization requests are also accepted from SNFs for existing residents when the SNF believes that a San Diego Medi-Cal Managed Care Plan (MCP) client may meet the criteria for either SNF Patch or NBU Patch.

Please note: Funding for County Funded SNF, SNF Patch, or NBU Patch is intended to provide support for the client's serious and persistent mental illness. For SNF Patch and NBU Patch, the San Diego Medi-Cal Managed Care Plan is responsible for paying for the daily SNF bed rate. For County Funded SNF, the Managed Care Plan has denied SNF level of care, or the client has no medical needs requiring 24/7 skillable nursing care placement.

Initial Criteria and Referral to County Funded Skilled Nursing Facilities

How to Make a Referral to County Funded SNF, SNF Patch, or NBU Patch for a Client at an Acute Care Psychiatric Hospital

Please review the San Diego County Funded Long-Term Care Criteria on the website at optumsandiego.com. Clients in an acute care psychiatric hospital who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego (and are not entitled to comparable services through other systems), may be referred for County SNF funding if the client has a primary mental health diagnosis that prohibits the client from being managed at a lower level of care, and the client meets all other criteria listed for the SNF level of care being requested.

Please follow these procedures when a client is being referred from an acute psychiatric hospital:

- Review the Admission Criteria for each SNF level of care and assess the client's appropriateness for referral and authorization through Optum. Verify the client has active San Diego Medi-Cal. Note the client's Medi-Cal Managed Care Plan (MCP) and contact the MCP plan before Optum if the primary reason for SNF placement is due to a skillable medical nursing need.

- If appropriate for referral to Optum, compile all required authorization request materials for a specific SNF level of care and submit to Optum LTC by fax to (888) 687-2515. A list of required documents necessary for authorization request is available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals.

- For County Funded SNF referrals: If client meets County Funded SNF admission criteria, Optum will notify the referring hospital. A list of facilities contracted or credentialed with Optum to accept County Funded SNF referrals is available at optumsandiego.com > Referrals > Levels of Care > County Funded Skilled Nursing Facility. The hospital is responsible for finding placement in a SNF that is contracted with Optum. Once approval is given by Optum, the hospital may coordinate admission with the accepting facility.

- For SNF Patch and NBU Patch referrals: Once funding source is secured to pay the daily rate for the SNF bed, and if client meets all other criteria for SNF Patch or NBU Patch admission, Optum will notify the referring hospital and send the referral directly to the contracted Patch or NBU Patch facilities. Determinations from the contracted facilities will be sent to Optum and the referring hospital. Once approval is received from both Optum and an accepting facility for Patch/NBU and arrangements have been made to bill the MCP for the SNF daily bed rate,

the hospital may coordinate admission with the accepting facility. Please note that Patch or NBU Patch funding is meant to augment a previously secured SNF bed day payment source.

- Once the client admits to the SNF, the accepting facility will notify Optum in writing and an authorization will be generated.

- If the authorization request does not meet Optum/County SNF admission criteria, Optum will verbally notify the requestor and send a Letter of Determination (LOD) to the fax number provided on the Long Term Care Referral Screening Form. 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.

- If San Diego SNFs are interested in becoming credentialed and contracted with Optum, they may call our provider line at (800) 798-2254, option 7 for more information on that process.

How to Make a Referral to County Funded SNF, SNF Patch, or NBU Patch 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 SNF funding through the County of San Diego, please follow these steps:

- SNF Provider must be credentialed and contracted with Optum for County Funded Long Term Care; please call our provider line at (800) 798-2254, option 7 for more information on that process.

- Review the Admission Criteria for the appropriate SNF level of care here: optumsandiego.com to assess the client's appropriateness for referral and authorization through Optum. Verify the client has active San Diego County Medi-Cal.

- Contact the San Diego Medi-Cal Managed Care Plan before Optum if the primary reason for SNF placement is due to a skillable medical nursing need.

- The San Diego County Funded Long-Term Care Criteria at optumsandiego.com outlines requirements for referral such as: clients who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego, clients who are not entitled to comparable services through other systems, clients who have a primary mental health diagnosis that prohibits them from being managed at a lower level of care, and clients who meet all other criteria listed for the requested SNF level of care.

- If appropriate for referral, compile all required documentation for authorization request and submit to Optum LTC by fax to (888) 687-2515. A list of required documents is available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals. To ensure Optum is able to make a timely and appropriate authorization decision, please submit complete and accurate referral packets.

- For County Funded SNF level of care, Optum may request a MCP denial be included with the authorization request.

- If the request is for Patch or NBU Patch funding, documentation must meet the San Diego County Funded Long-Term Care Criteria and demonstrate the client's need for additional support. Authorization request must include proposed interventions. Distributing psychiatric medication, in addition to medical medications, is not sufficient enough intervention and support to meet criteria for Patch level of care.

- When an individual meets the Admission Criteria for County Funded SNF, SNF Patch, or NBU Patch, Optum will verbally notify the SNF and upon admission will send a written authorization letter. When the authorization request does not meet admission criteria, Optum will verbally notify the SNF 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.

Forms for Referral and Authorization Requests

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals > Referral Forms:

- County Funded Skilled Nursing, SNF Patch, and NBU Criteria
- County Funded SNF, SNF Patch, and NBU Referral Requirements
- County Funded SNF, SNF Patch, and NBU Referral Process
- Mini-Cog™Exam
- Case Manager Recommendation
- Representative Payee Form
- Long Term Care Referral Screening Form
- Long Term Care Referral Screening Form Tip Sheet

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Long Term Care Facilities > ALL:

- Admission Form
- Bed Hold Return
- LTC Administrative Days Request
- LTC Appeal Form

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Long Term Care Facilities > Skilled Nursing Facilities:

- SNF Bed Hold Request
- SNF Patch-NBU Referral Determination
- Skilled Nursing Facilities Concurrent Review Template
- Skilled Nursing Facility Discharge Notification

Initial Authorization for County Funded Skilled Nursing Facilities

Optum Utilization Management (UM) is responsible for providing an initial authorization for clients who meet San Diego County Funded Long-Term Care Criteria for County Funded SNF, SNF Patch, or NBU Patch. After Optum approves a client for admission to one of these levels of care, (see Initial Referral to County Funded Skilled Nursing Facilities section), the admitting SNF is responsible for informing Optum in writing of the date of admission to the County Funded SNF, SNF Patch, or NBU Patch. This is the date that the SNF facility is requesting County funded payment to begin. Please follow these steps:

- The admitting facility shall complete the Admission Form, indicating level of care previously approved by Optum and send to Optum LTC by fax to (888) 687-2515.
- An initial 90-day authorization will be issued, and an authorization letter will be sent to the SNF facility.
- Additional authorizations follow the Continued Stay Authorization for County Funded Skilled Nursing Facilities process outlined in this handbook.

Continued Stay Criteria for County Funded Skilled Nursing Facilities

Concurrent reviews are used to request additional authorization from Optum and shall be submitted prior to the end date of the current authorization time period. Concurrent reviews for continued authorization are due two (2) weeks prior to the expiration of the previous authorization. Subsequent concurrent reviews will be at a frequency based on clinical presentation, no less than thirty (30) days and no more than one hundred and eighty (180) days from the last review, and are dependent on clinical documentation, level of impairment, and progress towards discharge plan.

Provider delay in submitting a concurrent authorization request to Optum UM LTC department, may delay claims payment. Incomplete submission or failure to submit an authorization request, may result in non-payment for the stay in the Long Term Care facility if authorization request is retroactively reviewed and the request is deemed to not meet criteria. Incomplete submissions are not authorized and without authorization, services may not be reimbursed.

To be approved, the authorization request must meet the following criteria for continued stay in a County Funded SNF, SNF Patch, or NBU Patch:

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 intense 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. If clinically indicated, there is an appropriate discharge plan to a less restrictive level of care that considers the client's recovery goals and preferences and allows for treatment gains to be maintained/enhanced. Any applicable barriers to potential discharge shall be explored and appropriately addressed.

8. For County Funded SNF, Optum may request with the continued stay authorization request, documentation showing that the responsible Medi-Cal Managed Care Plan re-evaluated client, as clinically indicated or as appropriate, and determined that the client does not meet the Managed Care Plan's SNF Level of Care criteria.

9. The primary focus of treatment for the level of care funded through the County of San Diego, is not a physical health condition that requires skilled nursing care.

And the authorization request 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 of 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.

   b. A lower level of care in which the 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 an Optum Medical Director after consultation with San Diego County's Medical Director and applicable County Contracting Officer's Representative.

Continued Stay Authorization for County Funded Skilled Nursing Facilities

Please follow these procedures when requesting a continued stay authorization by submitting a concurrent review prior to the end date of the current authorization time period:

- The SNF is required to request continued stay authorization at least fourteen (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 sent to the SNF.

- Review the Continued Stay Criteria for County Funded Skilled Nursing Facilities section for County Funded SNF, SNF Patch, or NBU Patch to assess the patient's appropriateness for continued stay through Optum. Confirm that the client has active San Diego Medi-Cal funding.

If client appears appropriate for continued stay, complete the Skilled Nursing Facilities Concurrent Review Template located at optumsandiego.com and submit to Optum LTC by fax to (888) 687-2515.

- Optum will review the documentation and make an authorization determination within fourteen (14) calendar days of receiving complete information.

- Optum will authorize between thirty (30) days and one hundred and eighty (180) days for continued stay if criteria is met. An authorization letter, with the last day authorized, will be sent to the facility.

- If the authorization request does not meet Optum/County Continued Stay Criteria, Optum will issue a Continued Stay Notice. The Continued Stay Notice 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 and send a Letter of Determination (LOD) to the fax number provided by the SNF.

Bed Hold Days for County Funded SNF, SNF Patch, or NBU Clients

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, and the SNF anticipates re-admitting the client and is willing to hold the bed for that client, the SNF may consider use of a bed hold. If the SNF does not anticipate re-admitting the client, the SNF submits a Skilled Nursing Facility Discharge Notification found at optumsandiego.com > Long Term Care Facilities > Skilled Nursing Facilities. Please note: County Funded SNF is the only level of care eligible for reimbursement for the bed hold rate through Optum. Since the Medi-Cal Managed Care Plan (MCP) is the primary payor for the SNF bed day rate for both SNF Patch and NBU Patch, the MCP should be paying for the bed hold day for those clients. For all SNF clients, please notify Optum of the bed hold so that Optum may support the SNF provider and also coordinate with any other community stakeholders as needed.

Optum will approve a bed hold of up to seven (7) days for hospital admission or AWOL. 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 or notifying Optum of a bed hold:

- SNF facility notifies Optum Utilization Management in writing when a client becomes AWOL or is admitted to a hospital. Complete the SNF Bed Hold Request Form available at optumsandiego.com and fax the SNF Bed Hold Request Form to Optum LTC at (888) 687-2515. Include details of what led up to the bed hold and the location of the client if hospitalized.

- Optum will review the request and approve a bed hold of up to seven (7) days for a hospital admission or when a client is AWOL.

- If a client is hospitalized and additional time is needed, an extension may be requested by notifying the Optum Medical Director and Optum Long Term Care team and approval may be sought from applicable County Contracting Officer's Representative (COR). For extension requests, attach the original SNF Bed Hold Request Form and provide updates including where the client is, treatment being provided, and anticipated return date. If approved, updates shall be provided in 7-day increments.

- If a client returns to the SNF prior to the end of the bed hold, the SNF shall notify Optum of the date the client is re-admitted to the SNF by completing the Bed Hold Return Form available at optumsandiego.com > Long Term Care Facilities > ALL and faxing the form to Optum LTC at (888) 687-2515. This notification is required at the time of the client's re-admission to the SNF.

- If a client does not return to the SNF by the end of the bed hold, the SNF facility is expected to discharge the client (as of the day after the bed hold ends).

- Please follow the Discharge from County Funded SNF, SNF Patch, or NBU Patch procedure provided in this handbook.

- For County Funded SNF bed holds: A bed hold authorization will be entered.

- For SNF Patch or NBU Patch bed holds: There will be a gap in the Optum authorization during the bed hold, as no services were provided to the client by the facility during the dates of the bed hold. The Medi-Cal Managed Care Plan (MCP) is the primary payor for the SNF bed day rate for both SNF Patch and NBU Patch; please contact the MCP if applicable for any bed hold day payment.

Discharge from County Funded SNF, SNF Patch, or NBU Patch

The SNF is required to inform Optum in writing at the time of a client's discharge from the SNF. This is done by fully completing the Skilled Nursing Facility Discharge Form available at optumsandiego.com > Long Term Care Facilities > Skilled Nursing Facilities and faxing to Optum at (888) 687-2515. Please note: The day of discharge is not a billable day. The SNF is also required to coordinate the discharge with the client's case manager, conservator, legal representative, and/or family as appropriate.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Procedure for Submitting 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 appeal 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 Quality Improvement within seven (7) 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 seven (7) days of receipt of the letter or notice
- Mail, fax, or secure email the appeal form and the supporting documentation to:

  Optum, Quality Improvement Department
  PO Box 601370
  San Diego, CA 92160-1370
  Fax: (844) 897-5479
  SDQI@optum.com

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. Optum will forward the County's determination letter to the SNF. The appeal process will take approximately fourteen (14) days from the date Optum receives the appeal.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Procedure for Submitting 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 there is difficulty finding placement prior to the end of the authorization, 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 Days, 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 and is also on optumsandiego.com.

- Mail, fax, or secure email the written request to:

  Optum, Quality Improvement Department
  PO Box 601370
  San Diego, CA 92160-1370
  Fax: (844) 897-5479
  SDQI@optum.com

- Optum forwards the request and supporting documentation to the County of San Diego. The County of San Diego staff will review the supporting documentation and make a determination. The facility receives a written outcome from Optum within fourteen (14) days.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Claims and Billing

Optum, 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 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.

Debarment and Exclusions Requirement and Monthly Attestation Letter

SNFs 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: exclusions.oig.hhs.gov.

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, the eligibility of staff working with County of San Diego clients by checking the following website: medi-cal.ca.gov (search under "Medi-Cal 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 Debarment and Exclusion 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 Debarment and Exclusion Attestation Form is received by Optum Provider Services. The required Debarment and Exclusion Attestation Form is provided with the contract.

Submitting Claims for County Funded Skilled Nursing Facilities

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 form.
3. The following data elements must be included on the UB-04 form. Claims submitted without these data elements will be denied.

Box #	Field Name	Instructions
1	Facility Information	Enter the facility name, address, telephone and county, zip code.
2	Pay-to Name and Address	Enter the Pay-to Name and address of provider submitting the bill.
4	Type of Bill	Enter the type of bill for the purposes of third-party processing of the claim such as inpatient of outpatient.
5	Federal Tax Number	Enter the Tax Identification Number (TIN) or the Employer Identification Number (EIN). This number is assigned by the federal government for tax reporting purposes.
6	Statement Covers Period	Enter the beginning and end dates of service for the period reflected on the claim MMDDYY.
8b	Patient Name	Enter the patient's last name, middle initial, and first name.
9a	Patient Address	Enter the patient's street address, or P.O. Box or RFD, city, state, ZIP code.
9b	City Address	Enter the patient's city.
9c	State	Enter the patient's State code.
9d	ZIP Code	Enter the patient's ZIP code.
10	Patient Birth Date	Enter the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Patient Sex	Enter the sex of the client. Enter M for male or F for female.
38	Responsible Party Information	Enter the name and address of the person responsible for the bill.
42	Revenue Code	Enter the appropriate HIPAA compliant numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/ancillary service. See Revenue Code and Description table below.
44	HCPCS/ Rate/ HIPPS Code	Enter the appropriate HCPCS codes for ancillary service, the accommodation rate for bills for inpatient services, or SNF HIPPS (Health Insurance Prospective Payment Systems) rate codes for specific patient groups that are the basis for payment under a prospective payment system.
46	Service Units	Enter the number of inpatient SNF days are reported.
47	Total Charges	Enter the total charges covered and non-covered related to the current billing period.
50	Payer Name	If more than one payer is responsible for the claim, enter the names of primary, secondary, and tertiary payers as applicable.
58	Insured's Name	Enter the name (last, first name, middle initial) of the individual who carries the insurance benefits. This must match the name of the insured's BIC Number.
60	Insured's Unique ID	Enter the unique number that Medi-Cal assigns the client to insure the individual Medi-Cal Benefits Identification Card (BIC).
66	Diagnosis Code	Enter the ICD-10 CM code. All diagnosis billed based on UB-04 must be entered.

Revenue Code	Revenue Code Description
0185*	Bed Hold (N/A for Patch/NBU)
0190	Subacute
0191	Subacute Level I
0192	Subacute Level II
0193	Subacute Level III
0194	Subacute Level IV
0195	Psychiatric SNF Patch
0196	Neurobehavioral SNF Patch
0199	Other Subacute

*** Please note-revenue code 0185 is not for use with Patch or NBU Patch clients. Bed Hold billing for Patch or NBU Patch should be sent to the Medi-Cal Managed Care Plan.**

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

1

2

3a PAT. CNTL #

b. MED. REC. #

4

5

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME

8b – 9d

9 IDENTIFICATION NUMBER

10 BIRTHDATE

11

12 ADMISSION DATE

13 HR

14 TYPE

15 SRC

16 DHR

17 STAT

CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28

29 ACDT STATE

30

31 OCCURRENCE CODE DATE

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

42 REV CD

43 DESCRIPTION

44 HCPCS / RATE / HIPPS CODE

45 SERV DATE

46 SERV UNITS

47 TOTAL CHARGES

48 NON-COVERED CHARGES

49

PAGE

CREATION DATE

TOTALS

50 PAYER NAME

51 HEALTH PLAN ID

52 REL INFO

53 ASSIG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56 NPI

57 OTHER PRV ID

58 INSURED'S NAME

59 P REL

60 INSURED'S UNIQUE ID

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 Enter all Dx

A B C D E F G H I J K L M N O P Q R S T

66

67 ADMIT DX

68

69 PATIENT REASON DX

a b c

70 PPS CODE

71

72 ECI

a b c

73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

81CC

a

b

c

d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 thirty (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.

Overpayment

Overpayments may be offset against future claims payments. In such cases, the facility will be notified of the action and given thirty (30) days to appeal. Appeals should be submitted as described in the Procedure for Submitting Long Term Care 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 by phone or fax.
Facilities may call (800) 798-2254, Option 2 for all claims related inquiries. Facilities may also submit questions by fax 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

Acknowledgment of written appeals will be mailed to the facility within two (2) business days of receipt. Supporting documentation must include the client's 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 thirty (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.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

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 at optumsandiego.com > BHS Provider Resources > Fee for Service Providers > Compliance. 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) Serious Incident Report within 72 hours of the occurrence, using the confidential Serious Incident Report Form located at optumsandiego.com > BHS Provider Resources > Fee for Service Providers > Compliance. 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.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Complaints about Administrative and Contract Issues

Complaints about Optum administrative procedures, referral authorizations, forms, response, or lack of response by an Optum employee, as well as other general questions and concerns about policies and procedures, can be discussed with any Optum staff person with whom the provider comes in contact. Optum documents the content of the complaint and is obligated to come to a resolution within thirty (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 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 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.

Optum