TAR for Long Term Care: 20-1 Form

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This section contains information about the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1). For general policy information, refer to the *TAR Completion for Long Term Care* section of this manual. For online eTAR submissions, refer to the eTAR User Guide for Inpatient, Outpatient, & Long Term Care Services on the Medi-Cal website.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

Initial LTC TAR Submission Requirements

Long Term Care Treatment Authorization Requests (LTC TARs) for initial authorization of LTC services must be submitted to the TAR Processing Center for adjudication of paper TARs. LTC facilities must adhere to the following procedures when requesting authorization in free-standing and Distinct Part (DP) LTC facilities.

Before long term care can be authorized for a Medi-Cal recipient, the following documents must be submitted:

- LTC TAR
- PASRR Level I screening (if appropriate)
- ‹‹PASRR determination (if appropriate). See *Preadmission Screening and Resident Review* section of this manual for a list of PASRR exemptions.
- Asterisked (*) portions of the MDS Form 3.0.†♦››
- Hudman v. Kizer documentation as appropriate (DP/NF-B only) See the *TAR Criteria for DP/NF Authorization (Hudman v. Kizer)* section of this manual for information.
- ‹‹*Certification for Special Treatment Program Services* form (HS 231) for ICF-DD and STP TAR requests. Ω
- *Medical Review/Prolonged Care Assessment* (PCA) form (DHCS 6013A) for ICF-DD TAR requests)
- Medicare denial (if appropriate)
- MC 171: See the *Admissions and Discharges* section in this manual for information regarding the MC 171 form.››

Reauthorizations

The following procedures must be followed when requesting reauthorization of LTC services:

- Nursing facilities must complete the MDS Quarterly Review for each recipient, or a recently completed MDS.
- Complete the *Certification for Special Treatment Program Services* form ICF-DD and STP TAR requests (HS 231). ‹‹♦››
- The LTC reauthorization must be submitted to the TAR Processing Center for paper TARs or electronically through the Medi-Cal website for eTARs along with the completed sections of the MDS Quarterly Review the PASRR determination, as appropriate. For more information, see the *Preadmission Screening and Resident Review (PASRR)* section in this manual.

Adjudication Response (AR)

The field office will adjudicate the LTC TAR and generate an *Adjudication Response* (AR) that will be sent to the submitting provider. The AR lists the status of all service lines submitted on the TAR.

Authorization for Medi-Cal benefits will be valid for the number days specified by the consultant on the *Adjudication Response* (AR). Services must be rendered during the valid “From Date of Service-Thru Date of Service” period.

For additional information about ARs, providers may refer to “TAR Status on Adjudication Response” in the *TAR Overview* section of the Part 1 manual.

LTC TAR Authorization Time Period

LTC TARs for recipients of the following LTC facilities may be approved up to two years for initial and reauthorization requests: †

- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H)
- Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N)
- NF-A
- NF-B

Approval depends on attached documentation showing medical necessity, current care needs and recipient prognosis. ‹‹ICF/DD, ICF/DD-H and ICF/DD-N facilities require an HS 231 signed by the regional center with the same time period requested as the TAR. A DHCS 6013A or the information found on the PCA form in any format is required.›› Additional support documents, such as copies of eye exams, psychological assessments or dental exams are not required to be sent with the LTC TAR. The HS 231 and PCA forms are available in the “Forms” area of the Medi-Cal website (*www.medi-cal.ca.gov*).

ICF/DD-N facilities are required to include an Individual Service Plan (ISP) whenever a TAR reauthorization is submitted for a recipient. ISP submissions are required as part of the periodic review of ICF/DD-N facilities by the Medi-Cal Utilization Management Review Team as mandated by Title 22, Section 51343.2(k) of the *California Code of Regulations* (CCR).

The criteria for the two-year TAR is the same as the criteria for the authorization of services up to six months to one year (*California Code of Regulations* [CCR], Title 22, Sections 51120, 51124, 51334, 51335, 51343, 51343.1 and 51343.2).

Reauthorizations for Two-Year LTC TARs

Providers should submit reauthorization requests for two-year LTC TARs to the TAR Processing Center for paper TARs or electronically through the Medi-Cal website for eTARs.

Facilities/Recipients Not Qualified for Two-Year Authorization

The following facilities or recipients do not qualify for two-year TARs due to medical necessity of the recipient, current care needs or recipient prognosis documentation requirements:

- Subacute care facilities follow TAR requirements in CCR, Title 22, Section 51335.5 and 51335.6. See the *Subacute Care Programs: Adult* section in this manual for additional information.
- ‹‹For Special Treatment Program (STP) services in a locked NF-B that provides therapeutic programs to an identified mentally disordered population group, follow the requirements in CCR, Title 22, Section 51511.1.›› This population group requires reassessment every four months, as required under CCR, Title 22, Section 72445. ‹‹Authorization may be granted for up to four months. For more information on STP services, refer to “Special Treatment Program for the Mentally Disordered – Developmentally Disabled Program” in the Licensing and Certification for Long Term Care section of this manual.››

Medical Transportation

Medical transportation may be required for patients in LTC facilities. Since LTC facilities cannot bill for medical transportation, providers should use the following guidelines for ordering medical transportation.

Non-Emergency Ground Medical Transportation

Non-Emergency Coverage

Non-emergency medical transportation is covered only when a recipient’s medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Transport is not covered if the care to be obtained is not a Medi-Cal benefit.

Non-emergency medical transportation (NEMT) necessary to obtain medical services is covered subject to the written authorization of a licensed practitioner consistent with their scope of practice. Additionally, if the non-physician medical practitioner is under the supervision of a physician, then the ability to authorize NEMT also must have been delegated by the supervising physician through a standard written agreement.

Providers that can authorize NEMT are physicians, podiatrists, dentists, physician assistants, nurse practitioners, certified nurse midwives, physical therapists, speech therapists, occupational therapists and mental health or substance use disorder providers.

Non-Emergency Transportation Requiring Authorization

A *Treatment Authorization Request* (TAR) is required for non-emergency transportation. A legible prescription (or order sheet signed by the physician for institutional recipients) must accompany the TAR.

Prescription Requirements

The prescription (or order sheet signed by the physician for institutional recipients) that is submitted with a TAR must include the following:

- Purpose of the trip
- Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation
- Medical or physical condition that makes normal public or private transportation inadvisable

Note: When transportation is requested on an ongoing basis, the chronic nature of a recipient's medical or physical condition must be indicated and a treatment plan from the physician or therapist must be included. A diagnosis alone, such as "multiple sclerosis" or "stroke," will not satisfy this requirement.

Non-emergency medical transportation services require a prescription from a physician, dentist, or podiatrist. Authorization is also required for non-emergency medical transportation.

All TARs for non-emergency medical transportation must be submitted to the TAR Processing Center for paper TARs or electronically through the Medi-Cal website for eTARs.

Non-Emergency Transportation Requiring Authorization

Non-emergency medical transportation services do not require a prescription or authorization when billing with codes A0130, A0380, A0422, A0425, A0426, A0428, T2001 or T2005 in conjunction with modifiers HN + QN (transfer of a patient from an acute care hospital to a Nursing Facility [NF] Level A or B).

Transport From Acute Care Hospital to Long Term Care Facility

A TAR, prescription or clinician signature is not required for non-emergency transportation from an acute care hospital to a long term care facility. This is the only exception to the TAR requirement for non-emergency medical transportation, as stated in CCR Title 22, Section 51323[b](c). All other non-emergency medical transportation with a different origin or destination other than as stated requires a TAR. This policy applies to transportation for recipients who received acute care as hospital inpatients who are being transferred to a Nursing Facility (NF) Level A or B.

This service must be billed with one of the appropriate non-emergency transportation codes (HCPCS codes A0130, A0380, A0422, A0425, A0426, A0428, A0434, T2001, T2005). Refer to the *Medical Transportation – Ground: Billing Codes and Reimbursement Rates* section in this manual for code descriptions and rates. Services billed with other non-emergency transportation codes require authorization.

Note: Medi-Cal does not cover waiting time or night calls for transport from an acute care facility to NF-A care.

Dry Run Transport From an Acute Care Hospital to a Long Term Care Facility

Providers may be reimbursed for responding to a transport service request from an acute care hospital to a Nursing Facility (NF) Level A or B without transporting the recipient (dry run). To bill for a dry run transport from an acute care hospital to a NF Level A or B, providers must use A0130, A0426, A0428 or T2005 with modifier HN followed by modifier QN. No other modifiers or service lines may be billed on the claim. This service does not require a TAR.

For additional information on non-emergency medical transportation, refer to the *Medical Transportation – Ground* section of the Medical Transportation Provider Manual.

Admitting a Recipient From the Community or Another Nursing Facility

The following procedures are used when a recipient enters an NF from the community or another NF.

- The LTC TAR must be completed by the NF. Instructions for filling out the LTC TAR form are on following pages.
- The PASRR determination must be completed. See the *Preadmission Screening Resident Review (PASRR)* section in this manual for instructions on completing the PASRR Level I screening.
- The PASRR determination is not necessary if it is anticipated that the recipient will be staying in the NF less than 30 days.
- The portions of the MDS marked with an asterisk (*) must be completed by the NF and submitted with the initial LTC TAR. ‹‹†››
- If the recipient is eligible for both Medicare and Medi-Cal, a Medicare denial must be submitted with the LTC TAR.
- ‹‹The MC 171 form must be completed by the NF and submitted with the TAR if the recipient has been discharged from the NF prior to LTC TAR submission.›› See the *Admissions and Discharges* section in this manual for information regarding the MC 171 form.
- Complete *the Certification for Special Treatment Program Services* form (HS 231).‹‹♦››

The appropriate Medi-Cal field office will adjudicate the LTC TAR and return an AR to the submitting provider.

Admitting a Recipient From a General Acute Care Hospital

It is also the nursing facility's responsibility to complete the MDS 3.0 and to send it and the LTC TAR as indicated on a previous page. See the *TAR for Long Term Care: MDS Form* section in this manual for instructions regarding the MDS 3.0 Form.

The nursing facility must submit all required documents for adjudication of the LTC TAR. After TAR review, an *Adjudication Response* (AR) will be sent to the submitting provider. For additional information about ARs, providers may refer to "TAR Status on Adjudication Response" in the *TAR Overview* section of the Part 1 manual.

Note: This does not apply to facilities with ICF-DD levels of care.

Admission to Nursing Facility Level B Certified for Medi-Cal Only

A Medicare/Medi-Cal crossover recipient may be admitted to a non-Medicare certified NF-B after a qualifying acute hospital stay when the following conditions are met:

- If it is determined that the recipient would not be eligible for coverage under the Medicare program, the field office requires a facility Medicare denial or certification from the hospital utilization review committee that the recipient does not meet Medicare criteria for skilled nursing care coverage.
- If the recipient may be eligible for benefits under the Medicare program, the skilled nursing facility will be required to obtain a Medicare denial through an arrangement with a utilization committee of a Medicare certified NF-B facility or Professional Standards Review Organization (PSRO).
- At the time the initial LTC TAR is submitted to the Medi-Cal consultant for approval, all medical information, including hospital discharge summaries, must accompany the authorization request. If review of the LTC TAR and MDS 3.0 by the Medi-Cal consultant indicates that the recipient may have been eligible for coverage under the Medicare program, the Medi-Cal consultant may request review by a utilization review committee of his or her other choice prior to approval of the initial TAR.

A 14-day denial of Medi-Cal coverage will be applied if, after review of material submitted, a determination is made that the recipient would have been covered under the Medicare program in a certified Medicare facility.

Medicare/Medi-Cal Crossover Recipients

The following is required for Medicare/Medi-Cal crossover recipients:

- A copy of the Medicare denial letter must accompany the LTC TAR for all Medicare/Medi-Cal crossover claims.
- Nursing Facility providers are required to submit a new LTC TAR along with the appropriate Medicare denial letter for recipients returning to a Nursing Facility after a three-day qualifying acute hospital stay.

Note: This does not apply to ICF/DD, ICF/DD-H, and ICF/DD-N facilities.

Authorization for Medicare/Medi-Cal Crossover Recipients

Authorization for Medicare/Medi-Cal crossover recipients is granted under the following conditions:

Three-Day Qualifying Stay

If the recipient has met the Medicare three-day qualifying stay in an acute care hospital and has Medicare benefits, a new LTC TAR must be submitted with the appropriate Medicare denial.

No Three-Day Stay in an Acute Hospital

If the Medicare recipient has not had a three-day qualifying stay in an acute care hospital, a facility denial stating this fact must be submitted with the LTC TAR and the recipient will be considered for Medi-Cal-only coverage.

Documentation Submitted When Medicare Available Days Denied

Any one of the following documents is acceptable to prove level of care denial in LTC and acute care hospital distinct parts:

- Facility denial
- Utilization review committee denial

Documentation Submitted Certifying Medicare Available Days

To certify available days for acute hospitals and for LTC, including acute hospital distinct parts, field offices will accept any one of the following:

- *Remittance Advice*
- Direct Data Entry (DDE) screen printout

LTC TAR Submission: Required Documents

Initial LTC TARs

- Completed LTC TAR
- MDS 3.0
- Subacute facilities submit the appropriate DHCS 6200 in lieu of MDS 3.0.
- Medicare denial (if appropriate)
- MC 171
- HS 231 (if appropriate)
- ‹‹PASRR Level I screening (if appropriate)››
- PASRR Level II determination (if appropriate). See *Preadmission Screening and Resident Review* section of this manual for a list of PASRR exemptions.
- ‹‹DHCS 6013A (if appropriate)››

Reauthorization LTC TARs

- Completed LTC TAR
- *MDS Quarterly Assessment Form* 3.0, or a recently completed (within the last four months) MDS 3.0
- Subacute facilities submit the appropriate DHCS 6200 in lieu of MDS 3.0
- HS 231 (if appropriate)
- ‹‹PASRR Level II determination (if appropriate)››

Level II Referral Processing

Level II Referral Processing Table

Recipient Coming From	‹‹Who Completes the PAS/PASRR Screening Document››	Who Refers to Level II
Community (Home, Board and Care, Another NF)	Admitting Nursing Facility	Admitting Nursing Facility
General Acute Care Hospital (GACH)	GACH	GACH

Providers may wish to copy this page and post it in the office.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
‹‹†››	Subacute facilities submit appropriate DHCS 6200 form instead of MDS 3.0
‹‹♦››	Facilities certified to bill for special programs (such as the Mentally Disordered Rehabilitation Program) and facilities approved for ICF-DD level of care must complete as indicated
‹‹Ω››	Not required for facilities approved for ICF-DD level of care.