Policy:	GG.1800
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 09/05/2024*
Effective Date:	06/01/1998
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the requirements for reviewing and processing Long-Term Care (LTC) authorizations for a Member's admission to, continued stay in, or discharge from a nursing facility under Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) levels of care.

II. POLICY

A. CalOptima Health's Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a nursing facility under Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) levels of care pursuant to the Department of Health Care Services (DHCS) standard clinical criteria in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long-Term Care Services.

B. CalOptima Health shall ensure that Members in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute Facilities, and Intermediate Care Facilities.

C. For initial admissions, a facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima Health LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active LTC ARF.

1. If a facility submits an LTC ARF after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima Health shall subject the authorization to a fifteen percent (15%) payment reduction. The rate of reduction is established by CalOptima Health and shall be

adjusted periodically, based on the LTC Facilities Annual Financial Reporting data from the California Office of Statewide Health Planning and Development (OSHPD).

D. CalOptima Health may decide, at its discretion, to perform an on-site level of care determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and a thorough review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data appropriate to support making the determination on the authorization request.

E. If CalOptima Health's review of the medical records and/or in-person assessment of the Member determines the authorization request for NF-B level of care does not meet clinical criteria because indicated acuity and care needs were too low, the authorization request will be reviewed by CalOptima Health's Medical Director against NF-A level of care clinical criteria. If the Member in such cases was determined to meet NF-A criteria by the Medical Director, a Modified Approval would be issued along with all standard appeals rights.

F. CalOptima Health shall review authorizations for short stays in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

G. CalOptima Health shall maintain a set of individuals as part of the Provider Relations Department to serve as the liaison for LTC facilities.

1. Liaisons shall receive training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, Provider resolution policies and procedures, and care management coordination and transition policies.

2. LTSS Liaisons shall assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support Member's needs. CalOptima Health shall identify these individuals and disseminate their contact information to relevant network Providers, including SNFs that are within the network.

3. LTSS Liaisons shall be engaged in the Member's Interdisciplinary Care Team (ICT), as appropriate for Member's accessing LTSS services.

III. PROCEDURE

A. CalOptima Health shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.

B. For a non-contracted facility requesting authorization for services, CalOptima Health shall verify if the facility:

1. Is licensed by the California Department of Public Health (CDPH);

2. Meets acceptable quality standards;

3. Signed a Letter of Agreement in order to obtain reimbursement in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting

4. Agrees to CalOptima Health rates, in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting.

C. A non-contracted facility shall provide the required documentation to CalOptima Health for Credentialing purposes as referenced in CalOptima Health Policy EE.1135: Long Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting and pursuant to CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers.

D. For initial admissions, a facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) (Sections I through V) with a physician's signature on the ARF or accompanied by a separate nursing facility long-term care order written by the physician, Minimum Data Set (MDS), Medicare or other insurance denial letter as appropriate, and Preadmission Screening and Resident Review (PASRR) Screening Level I Document forms within twenty-one (21) calendar days from the start date of CalOptima Health LTC coverage.

E. For re-authorizations of a continued stay, the facility shall submit an LTC ARF to the CalOptima Health LTSS Department at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The facility may submit a reauthorization LTC ARF up to sixty (60) calendar days prior to the expiration of the active LTC ARF. The requests shall include a completed LTC ARF (Sections I, III [as applicable], and IV), the most recent MDS Quarterly Assessment, and adequate documentation to justify the level of care and continued stay.

F. The LTC authorization process is initiated by the facility with the presentation of a completed LTC ARF along with supporting clinical records. CalOptima Health LTSS Department shall approve, modify, or deny the facility's request in a timeframe that is appropriate for the Member's medical condition, but no longer than five (5) business days from CalOptima Health's receipt of all information requested that is reasonably necessary to make a determination.

G. If the LTC ARF and required documents are incomplete, the CalOptima Health LTSS Department shall delay the approval process and return the incomplete LTC ARF and any attachments, if appropriate, to the facility for review and resubmission with additional clinical documents. CalOptima Health LTSS Department will notify the facility within twenty-four (24) hours of the decision to delay determination due to insufficient clinical documents. When unable to make a determination, the CalOptima Health nurse case manager will document the need for additional information, what information is required, and that the facility will have fourteen (14) calendar days from the initial presentation of the ARF to provide the documents. The facility shall resubmit the LTC ARF before the end of the fourteen (14) calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial.

H. If the nursing facility is unable to provide the additional requested documents within the fourteen (14) calendar days for CalOptima Health to make a determination, the Member or the nursing facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. Such a deferral request must be received within the initial fourteen (14) calendar day period. The LTSS nurse case manager will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the nursing facility and mailed to the Member. After a total of twenty-eight (28) calendar days, if the additional records are still not presented, the CalOptima Health nurse case manager will make a determination based on only the available documentation at that time.

I. For Medical Necessity determinations, if the CalOptima Health LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima Health LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Health Medical Director, or authorized physician designee, for review and determination.

1. If CalOptima Health's Medical Director, or physician designee, approves the LTC ARF, the CalOptima Health LTSS Department shall send an approval letter with the copy of the approved LTC ARF to the facility.

2. If CalOptima Health's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima Health LTSS Department shall notify the facility, the Member, or the Member's Authorized Representative in accordance with CalOptima Health Policies GG.1814: Appeals Process for Long Term Care Facility and GG.1508: Authorization and Processing of Referrals.

J. CalOptima Health may dismiss an authorization request for a OneCare Member, either entirely or as to any stated issue, under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an authorization under Title 42, Federal Code of Regulations, § 422.566(c).

2. CalOptima Health determines the party failed to make out a valid request for an authorization.

3. A Member or the Member's Authorized Representative files a request for an authorization but the Member dies while the request is pending, and both of the following apply:

   a. The Member's surviving spouse or estate has no remaining financial interest in the case; and

   b. No other individual or entity with a financial interest in the case wishes to pursue the organization determination.

4. A party filing the authorization request submits a timely request for withdrawal of their request for an organization determination.

K. CalOptima Health shall mail or otherwise transmit a written notice of the dismissal of the authorization request to the parties. The notice must state all of the following:

1. The reason for the dismissal;

2. The right to request that CalOptima Health vacate the dismissal action; and

3. The right to request reconsideration of the dismissal.

L. If the facility submitted the completed LTC ARF and all necessary clinical records to support an approval within the twenty-one (21) calendar day submission period, CalOptima Health shall approve the LTC ARF back to the date of the admission or the beginning of CalOptima Health coverage, whichever is later.

M. If the facility submits the LTC ARF and the necessary clinical records later than the twenty-one (21) calendar day submission period, and CalOptima Health approves the LTC ARF, CalOptima Health shall subject the LTC ARF to a fifteen percent (15%) payment reduction from the date of the

Member's admission up to the date on which the CalOptima Health LTSS Department received the completed LTC ARF.

N. CalOptima Health LTSS shall provide the Member and the facility with a written Integrated Denial Notice/Notice of Action, as appropriate, for any decisions to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. A written Integrated Denial Notice/Notice of Action will therefore also be provided for decisions to approve NF-B authorization requests at the NF-A level of care.

O. Upon receipt of an LTC ARF modification or denial, the Member and the facility shall both be eligible to file an appeal, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process and GG.1814: Appeals Process for Long Term Care Facility.

P. Transitional Care Services (TCS)

1. The CalOptima Health LTSS Department will provide transitional care services for LTC Members transferring from one setting or level of care to another, in accordance with CalOptima Health Policies GG.1357: Population Health Management Transitional Care Services (TCS) and GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care.

2. CalOptima Health will ensure TCS care managers are notified within twenty-four (24) hours when Members are admitted and discharged from LTC or transferred between facilities. LTC Nursing Facilities will notify CalOptima Health by fax to the LTSS Department.

3. The CalOptima Health LTSS Department will identify a care manager as a single point of contact for ensuring completion of all transitional care management services, including follow-up after discharge from LTC.

4. CalOptima Health will ensure Member transitions to and from LTC are timely and do not delay or interrupt any Medically Necessary services of care, and that all required transitional care activities are completed by meeting the following requirements, at a minimum:

    a. Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and TCS during all transitions;

    b. Assist Members being discharged or Members' parents, legal guardians, or Authorized Representatives by evaluating all medical care needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS and other Home and Community Based Services (HCBS);

    c. Maintain contractual requirements for Skilled Nursing Facilities (SNFs) to share Minimum Data Sets (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

    d. Ensure Member outpatient appointments or other immediate follow-ups are scheduled prior to discharge;

    e. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

f. Follow-up with Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, regarding the new care settings to ensure compliance with TCS requirements.

5. A discharge risk assessment will be completed prior to discharge to assess a Member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or substance abuse relapse.

6. Discharge planning documents shall include, but are not limited to:

   a. Pre-admission status, including living arrangements, physical and mental function, Substance Use Disorder (SUD) needs, social support, Durable Medical Equipment (DME) uses, and other services received prior to admission;

   b. Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

   c. The LTC facility to which the Member was admitted;

   d. Specific agency or home recommended by the LTC facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of the type of placement agreed to by the Member, specific description of agency or Member's return to the home agreed to by the Member, and recommended pre-discharge counseling;

   e. Summary of the nature and outcome of participation of the Member, Member's parents, legal guardians, or authorized representatives in the Discharge Planning process, anticipated problems in implementing post discharge plans, and further action completed by the LTC facility to be included in the Member's Medical Record; and,

   f. Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from the LTC facility.

7. The assigned care manager will ensure that Discharge Planning documents are shared with Members, Member's parents, legal guardians, or Authorized Representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider to facilitate communication and information sharing of the Member's specific discharge plan.

8. Upon discharge from LTC, LTSS staff will follow-up with the Member and provide referrals to other resources as needed, including, but not limited to: Case Management, Enhanced Care Management (ECM), and home and community supports.

Q. Upon notification by a facility of a Member's discharge, the CalOptima Health LTSS Department shall close the active LTC authorization, effective the day of discharge. The facility shall notify CalOptima Health within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to the LTSS Department and submitting a completed Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agency. The CalOptima Health LTSS Department shall notify the appropriate departments and Health Network for further care coordination.

IV. ATTACHMENT(S)

A. CalOptima Health Long-Term Care (LTC) Authorization Request Form (ARF)
B. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy EE.1135: Long Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting
C. CalOptima Health Policies GG.1357: Population Health Management Transitional Care Services (TCS)
D. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
E. CalOptima Health Policy GG.1510: Member Appeal Process
F. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
G. CalOptima Health Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
H. CalOptima Health Policy GG.1814: Appeals Process for Long Term Care Facility
I. CalOptima Health Policy GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care
J. CalOptima Health Provider Resource Manual
K. CalOptima Health Utilization Management Program
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notices and Your Rights
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing Facility – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)
N. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
O. Title 22, California Code of Regulations (CCR), §§ 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51212, 51215, 51334, and 51335
P. Title 42, Federal Code of Regulations, § 422.566(c), and 422.568.
Q. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/26/2016	Department of Health Care Services (DHCS)	Approved as Submitted
02/22/2021	Department of Health Care Services (DHCS)	Approved as Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
11/05/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/01/1998	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Revised	03/01/2008	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Revised	02/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	12/18/2018	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	11/05/2020	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	08/01/2021	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	08/01/2022	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare
Revised	05/01/2023	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare

Action	Date	Policy	Title	Program(s)
Revised	10/01/2023	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare
Revised	09/01/2024	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Case Management	Medi-Cal: A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. OneCare: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to members assigned to that health network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by members enrolled in CalOptima Health's OneCare program, consistent with applicable regulatory and contract requirements.
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Long Term Care (LTC)	Medi-Cal: Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Term	Definition
Medically Necessary/Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare (Duals): Means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program. OneCare: A beneficiary enrolled in a CalOptima Health OneCare Program.
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by members enrolled in the CalOptima Health Medi-Cal program, consistent with applicable regulatory and contract requirements.

Term	Definition
Nursing Facility Level A (NF-A)	Level of care characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
PASRR Level-I Screening	A screening completed by a nursing facility for each resident that is going to be admitted to a Medicaid certified nursing facility. The purpose of the Level-I screening is to identify a resident who has a mental illness or is suspected of having mental illness, an intellectual/developmental disability, or a related condition to determine if specialized services are needed during their stay in a nursing facility.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Skilled Nursing Facility (SNF)	Medi-Cal: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program. OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.