L.A. Care HEALTH PLAN®

# Environmental Asthma Trigger Remediation Service Authorization Request Form

***Please fax completed document to 213-438-4863.***

Environmental Asthma Trigger Remediations (hereinafter referred to as Asthma Remediation services) are for members with poorly controlled asthma. They are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. In order to start the request process, this form must be completed by a licensed healthcare provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high cost services.

***Required responses are identified with an asterisk.****

## Member Information

Member CIN Number:* _____ Date of Birth* _____ Phone Number:* _____

First Name:* _____ Last Name:*_____

Street Address:* _____

City:*_____Zip Code:* _____

## Parent/Authorized Representative Information (If Applicable)

First Name: _____ Last Name:_____

Phone Number:_____ Title/Relationship:_____

## Member Eligibility Criteria*

***Please select all that apply to the Member. At least one box must be selected.***

☐ In the past 12 months, Member has had an emergency department visit with asthma-related symptoms.

☐ In the past 12 months, Member has had a hospitalization with asthma-related symptoms.

☐ In the past 12 months, Member has had two sick/urgent care visits.

☐ Member has a score of 19 or less on the Asthma Control Test.

☐ Member has a recommendation from a licensed healthcare provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services.

If box is NOT checked, STOP. Member does not meet eligibility criteria. If box is checked, move on to next section

☐ Checking this box simply attests that you have discussed treatment with the Member, and you have received the Member's consent to proceed with a Service Authorization Request (SAR) for covered benefits and services that require medical necessity review and approval prior to scheduling any appointment. *

## Name of Person Completing This Form

Organization/Agency Name:*_____ Date:* _____

Organization/Agency NPI:*_____

Referring Individual's Name:*_____Referring Individual's Email:*_____

Referring Individual's Address: *_____ Requestor City:* _____

Zip Code:*_____ Referring Individual's Phone Number:*_____Fax Number:*_____

Referring Individual's Relationship to Member: * ☐ Medical Provider ☐ Social Services Provider ☐ Member/Family ☐ Other:_____

☐ **Check this box if you are an L.A. Care Asthma Remediation provider and are requesting to have the Member assigned to you.**

## Member Diagnosis

Member must have a valid Asthma diagnosis. The specific Asthma ICD-10 Code which applies to the member must be indicated. Write in the Asthma diagnosis and ICD-10 code below.

Asthma Diagnosis: *_____ ICD-10 Code:*_____

## Name of Licensed Healthcare Provider (MD, DO, NP, PA) Authorizing Order

National Provider Identifier (NPI):* _____ Phone Number:* _____ Fax Number:*_____

Provider Name:* _____ L.A. Care Provider ID: _____

***In order for the Member to qualify for Asthma Remediation services, you must provide the current licensed healthcare provider's NPI with this form. Stop here if this is the initial request for Asthma Remediation services.***

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## *For Asthma Remediation Providers Only*

Name of Asthma Remediation Provider/Organization:*_____

Name of Person Completing this Form:* _____Phone Number: *_____

Email: *_____ Date: *_____

***Required responses are identified with an asterisk.****

Asthma Remediation services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver up to a total lifetime maximum of $7,500.[1] Asthma Remediation services are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household.[2] Asthma Remediation Services that is a physical adaptation to a residence must be performed by an individual holding a valid California Contractor's License that is in good standing. Please see the CSLB License Check Website for more information: **Check A License - CSLB (ca.gov)**

☐ Checking this box simply attests that you have discussed treatment with the Member, and you have received the Member's consent to proceed with a Service Authorization Request (SAR) for covered benefits and services that require medical necessity review and approval prior to scheduling any appointment.*

☐ Checking this box simply attests that the Member IS NOT receiving duplicative support from other State, local, or federally-funded programs.*

☐ Checking this box attests that a written evaluation describing how and why the remediation(s) meets the needs of the member has been completed and is in the member's file.*

## Type of Service Authorization Request*

☐ **Initial**: The Member has not previously received Asthma Remediation services from L.A. Care or another health plan in California.

☐ **Continuation of Service**: The Member has previously received Asthma Remediation services from L.A. Care or another health plan in California.

If the Member has received Asthma Remediation services from another health plan in California, please specify which health plan(s) here:

_____

## Member Information

Member's CIN#:*_____ Date of Birth: *_____

First Name:* _____ Last Name:* _____

## Primary Location of Service

Street Address:* _____

City:* _____ Zip Code:*_____

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## Member Information

Member's CIN:* _____ Date of Birth:* _____

First Name:* _____ Last Name: * _____

## Type of Service

| Quantity | Qualifying Item | Value to Not Exceed (Per Quantity) | Requested Amount |
|---|---|---|---|
| | Allergen-impermeable mattress dustcovers | $175 | |
| | Allergen-impermeable pillow dustcovers | $17 | |
| | High-efficiency particulate air (HEPA) filtered vacuums | $400 | |
| | High-efficiency particulate air (HEPA) filters | $300 | |
| | Integrated Pest Management (IPM) services | $600 | |
| | De-humidifiers | $300 | |
| | Air filters/Air cleaners | $300 | |
| | Other moisture-controlling interventions | If this value exceeds $750, you must submit 2 bids. | |
| | Minor mold removal and remediation services[3] | $2,500 | |
| | Ventilation improvements[3] | If this value exceeds $750, you must submit 2 bids. | |
| | Asthma-friendly cleaning products and supplies | Itemized receipt to be submitted upon claim submission. | |
| | Other interventions identified to be medically appropriate and cost-effective | Submit an invoice request. The home assessment must describe how and why the remediation(s) meets the needs of the individual. | |
| | ***Total Amount*** | | |

## Name of Licensed Healthcare Provider (MD, DO, NP, PA) Authorizing Order

National Provider Identifier (NPI):* _____ Phone Number* _____ Fax Number* _____

Provider Name* _____ L.A. Care Provider ID _____

1. If Member had previously received Asthma Remediation services and this is the second round of request, please include information explaining how the Member's condition has changed so significantly that additional modifications are necessary.
2. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
3. Asthma Remediation Providers must obtain written landlord approval before commencement of permanent physical home adaptations, and must notify the landlord and Member with written documentation that the modifications are permanent and that the State is not responsible for maintenance, repair, or removal of any modification if the Member ceases to reside at the residence.