

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
GUIDELINE / PROCEDURE**

<b>Guideline/Procedure Number:</b> MCUG3038 (previously UG100338 and MCUP3105)			<b>Lead Department:</b> Health Services	
			<b>Business Unit:</b> Utilization Management	
<b>Guideline/Procedure Title:</b> Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities			<input checked="" type="checkbox"/> <b>External Policy</b>	
			<input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> 01/14/2027		
		<b>Last Review Date:</b> 01/14/2026		
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>		<input checked="" type="checkbox"/> <b>Medi-Cal</b>	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>	
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b>	<input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>	
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> 01/14/2026	

**I. RELATED POLICIES:**

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
- C. MPUP3139 – Criteria and Guidelines for Utilization Management
- D. MCUP3020 – Hospice Services
- E. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
- F. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- G. MPTP2501 – Transportation Policy for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
- H. MPQP1016 – Potential Quality Issue Investigation and Resolution
- I. MCRP4068 – Medical Benefit Medication TAR Policy
- J. MPAP7003 – CalAIM Community Supports
- K. MCAP7002 – CalAIM Enhanced Care Management (ECM)

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services
- D. Enhanced Health Services (EHS)
- E. Transportation
- F. Provider Relations
- G. Quality and Performance Improvement

**III. DEFINITIONS:**

- A. Custodial Care Facility: A non-medical facility (often referred to as a Long Term Care (LTC) facility) that provides basic assistance with daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability.
- B. Extended Care Facility (ECF): A healthcare institution that provides on-going medical care, rehabilitation services, and assistance with activities of daily living to individuals who require prolonged or specialized care. This is an all-inclusive term for facilities providing custodial, skilled and sub-acute services.
- C. Skilled Nursing Facility (SNF): A facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to complete a course of treatment that is not available in lower levels of care and support an increase in

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function, safety and independence with activities of daily living.

- D. Subacute Care Facility: A facility with a level of care that is less intensive than acute care but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
- E. Subacute Contracting Unit (SCU): A unit within the California Department of Health Care Services (DHCS), responsible for contracting with providers to offer Medi-Cal subacute care services. Contracted facilities may be reimbursed for subacute care services provided to Medi-Cal subacute beneficiaries who meet subacute care criteria as defined in Medi-Cal Manual of Criteria R-15-98E (adult beneficiaries) and Welfare and Institutions Code, section 14132.25 (pediatric beneficiaries). Specific reimbursement rates have been developed for providers of subacute care who have contracted with the DHCS' SCU.

#### IV. ATTACHMENTS:

- A. [Bed Hold/Change of Status Report form](#)
- B. [Skilled Nursing Facility Request Form](#)

#### V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Extended Care Facilities for Partnership HealthPlan of California Members.

#### VI. GUIDELINE / PROCEDURE:

- A. Identifying Members and Selecting Appropriate Extended Care Facilities (ECFs)
  - 1. Partnership ensures access to licensed care facilities, irrespective of location in or out-of-network, to Members in need of extended care services. These facilities may include:
    - a. Custodial/Long Term Care Facilities
    - b. Skilled Nursing Facilities (SNF)
    - c. Subacute Care Facilities (pediatric and adult)
  - 2. A Member in need of extended care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the Member to the appropriate type of facility.
  - 3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and Partnership Utilization Management (UM) team identifies the most appropriate level of care for the Member and assures that the Member is placed in a health care facility that provides the level of care most appropriate to the Member's medical needs.
    - a. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e).
    - b. DHCS Title 22 regulations, as well as CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*, are utilized by Partnership UM Nurse Coordinators when performing reviews of authorization requests to determine the medical necessity for continued placement in an extended care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/recommended.
  - 4. Extended Care Classification categories include the following:
    - a. Custodial/Long Term Care: These facilities assist members in meeting their activities of daily living (ADLs) such as eating, bathing, grooming, etc. Members must meet criteria showing need for this level of care. Following admission to the facility, members will continue to be

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- reevaluated periodically to ensure medical necessity is met for continued placement.
- b. **Skilled Nursing Care:** The Member may need a short-term stay for a skilled nursing care need or short-term rehab services and is expected to return to their previous living arrangement or alternate level of care. Facility staff, including case managers, are responsible for coordinating discharge planning for the member.
  - c. **Subacute Care:** The Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care either can either be short term, where there is potential for the Member eventually being transferred to a lower level of care; or custodial/long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these Members are authorized for time intervals based on the characteristics of the Member's medical condition.
5. The choice of an ECF for a patient is a decision that should include consideration of the following:
    - a. What are the medical/ rehabilitation needs for the member and does the facility have the services available to meet the Member's needs?
    - b. Is the facility a licensed Medi-Cal provider?
    - c. Is the facility contracted with Partnership?
    - d. Are there beds available?
    - e. If more than one choice is available, is there a family preference (e.g. geographical location) that can be reasonably accommodated?
    - f. Are there any benefit coverage limitations?
  6. Facility Requirements
    - a. An ECF must meet all of the following requirements:
      - 1) It must be a licensed institution
      - 2) It must be qualified as a provider of services under Medi-Cal
      - 3) It must maintain, on the premises, all facilities necessary for medical care and treatment
      - 4) It must provide such services under the supervision of a physician
      - 5) It must provide services given by or supervised by a registered nurse AND
      - 6) The facility must keep medical records on all patients
    - b. For Members approved for subacute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
- B. Members with Other Healthcare Coverage
1. When Members have other healthcare coverage (e.g., Medicare) Partnership will work to coordinate benefits as applicable.
- C. Treatment Authorization Requests (TARs) for Admission to an Extended Care Facility (ECF)
1. In alignment with [Manual of Criteria R-15-98E](#), an initial Treatment Authorization Request (TAR) is required with each admission to an ECF. A TAR is required when the Member:
    - a. Is a new admission to the facility
    - b. Has exhausted their Medicare benefits
    - c. Has received a denial from Medicare or other insurance for extended care
    - d. Is readmitted to an ECF from an acute care hospital
    - e. Returns to an ECF from an approved leave of absence beyond the approved return date
    - f. Is newly eligible with Partnership while residing in the ECF
    - g. Changes level of care (e.g. Skilled to Custodial, Custodial to Skilled, Subacute to Skilled)
  2. A UM Nurse Coordinator reviews the authorization request for medical necessity and level of care utilizing DHCS Title 22 regulations and/or CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*.
    - a. Cases not meeting criteria for medical necessity are referred to the Chief Medical Officer

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- (CMO) or Physician Designee for review and determination.
- b. Upon review, a UM Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity. Only the CMO/ Physician Designee can deny a TAR for reasons of medical necessity.
  - c. A determination will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
  - d. Partnership reserves the right to modify a request; it is the facility’s responsibility to review their request against what Partnership approves.
  - e. The facility is responsible for verifying the Member’s eligibility using Partnership’s “eEligibility” on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5<sup>th</sup> of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.
3. Extensions of Stay
    - a. Extensions of stay in extended care facilities for Medi-Cal Members require re-authorization by Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
    - b. Extension requests will be reviewed based on the facility’s documentation of the Member’s current clinical status and medical need of requested extension, including current services required, anticipated duration of services and progress towards goals of therapy in the prior approved stay, and current discharge disposition/ planning as noted by the facility’s team.
  4. Admissions on Weekends and Outside Normal Business Hours
    - a. If a member is transferred to a facility on a weekend, or outside normal business hours, Partnership must be notified via phone or the Online Services (OLS) portal on the next business day for immediate review of the TAR.
    - b. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.
  5. Custodial (Long Term Care) TAR Submission Requirements:
    - a. Custodial care services require prior authorization by a Partnership UM Nurse Coordinator before admission to a Custodial facility, otherwise, the stay may be denied for not meeting medical necessity.
    - b. A custodial care authorization request shall be initiated by the ECF, and the following documentation must be submitted with the initial Custodial Care TAR:
      - 1) Completed TAR form.
        - a) eTAR submission through Partnership’s Online Services (OLS) portal is recommended.
        - b) If Provider is unable to utilize the OLS portal, a [TAR form 20-1](#) may be faxed to (707) 863-4118.
      - 2) [MC171](#) (Medi-Cal Long Term Facility Admission and Discharge notification)
        - a) For Partnership members with Supplemental Security Income (SSI), the ECF is required to submit the MC171 form to the Social Security Administration (SSA) within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
        - b) Partnership’s Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form for all Partnership members with SSI. If a facility does not submit the MC171 form, the TAR will be sent to the CMO/Physician Designee for review and denied for "information requested not received." The facility will be notified.
      - 3) Medicare or other Insurance denial letter (if applicable)
      - 4) Completed Minimum Data Set (MDS) dated within the past 90 days
      - 5) PASRR ([Preadmission Screening and Resident Review](#))

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- c. When a member is admitted for custodial care, a TAR submission may be approved up to a six (6) month period.
- d. The Member's condition will be re-evaluated upon submission of a new TAR within 15 days of the expiration date of the previous TAR.
- e. Continued Care (Reauthorization) with a new TAR must include the following:
  - 1) Completed new TAR form
  - 2) Current MDS dated within 90 days of TAR start date
  - 3) Social Services annual review/quarterly assessment and progress notes
6. Skilled Nursing Facility (SNF) TAR Submission Requirements:
  - a. Skilled level nursing is a covered level of care for Partnership Members. This level of care is short-term for the acute rehabilitation stage of treatment following an illness or injury.
    - 1) A member in custodial care may be considered for short-term SNF level care for Isolation Days for communicable diseases per California Department of Public Health (CDPH) guidance and per the determination of the local health officer.
  - b. Admission to a SNF must be coordinated with a contracted Medi-Cal licensed facility by the discharge planner.
  - c. Skilled nursing services require prior authorization by Partnership before a Member's admission to a SNF.
  - d. The following documents must be submitted with the initial SNF TAR:
    - 1) Completed TAR form.
      - a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
      - b) If Provider is unable to utilize the OLS portal, a [TAR form 20-1](#) may be faxed to (707) 863-4118.
    - 2) PASRR ([Preadmission Screening and Resident Review](#))
    - 3) Acute notes
    - 4) Medicare or other health coverage denial letter
    - 5) Eligibility must be "No Other Insurance"
    - 6) Skilled Nursing Facility Request form (Attachment B)
    - 7) MD orders as applicable to facility type (see VI.C.8. and 9. below)
  - e. The following documents must be submitted for a SNF TAR extension:
    - 1) MD orders from SNF
    - 2) Nurse and attending physician/ medical provider notes showing medical need for SNF care (e.g. wound care, IV antibiotics) and anticipated duration of need
    - 3) Therapy progress report indicating current level of participation, progress notes and goals of treatment
    - 4) Discharge planning documents
7. Subacute Care Facility TAR Submission Requirements:
  - a. The following documents must be submitted with the initial Subacute Care Facility TAR:
    - 1) Completed TAR form.
      - a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
      - b) If Provider is unable to utilize the OLS portal, a [TAR form 20-1](#) may be faxed to (707) 863-4118.
    - 2) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services
      - a) Adult form: [DHCS 6200A](#)
      - b) Pediatric form: [DHCS 6200](#)
    - 3) Acute notes to include therapy notes (e.g. physical therapy, speech therapy, occupational therapy, respiratory therapy)
  - b. Note: For Members approved for sub-acute services, based on availability, Partnership verifies

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those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

- c. The following documents must be submitted for a Subacute TAR extension:
    - 1) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services (if dates are applicable)
      - a) Adult form: [DHCS 6200A](#)
      - b) Pediatric form: [DHCS 6200](#)
    - 2) Facility progress notes
    - 3) MD orders
  - d. Extensions of stay in subacute care facilities are reviewed in alignment with [Manual of Criteria R-15-98E](#) and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of six months.
    - 1) Extensions are reviewed based on medical need for the care that is provided. Facilities must provide current records showing the Member's current clinical status, participation in therapies, progress toward goals and discharge planning.
8. Authorizations for Transfers from Acute Care to an Extended Care Facility (ECF)
    - a. Please Note: If admission from acute care occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
    - b. The ECF is required to notify Partnership before any admission. Prior authorization is required for all admissions.
    - c. UM Nurse Coordinator will review documents and provide initial determination approval.
    - d. The transfer must be coordinated by the hospital discharge planner or case worker.
  9. Admission from Home to an Extended Care Facility
    - a. Please Note: If the admission from home occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
    - b. An ECF facility is required to notify Partnership before any admission. Prior authorization is required for all admissions from home.
      - 1) The following information must be submitted with the TAR:
        - a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in an ECF and the physician's certification that placement in the particular ECF is the appropriate level of care for the Member.
        - b) If placement follows an acute hospital stay within the past 30 calendar days, the hospital history and physical and discharge summary must be submitted.
        - c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months must be submitted.
  10. Bed Hold Change of Status Reporting
    - a. This occurs when a Member residing in an ECF is transferred to an acute care hospital or has an approved leave of absence, which must be reported through the Bed Hold/ Change of Status Report form (Attachment A).
    - b. The maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.

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- c. The following documents must be submitted when reporting a Bed Hold change of status:
    - 1) MD orders
    - 2) Bed Hold/Change of Status Report form (Attachment A)
  - d. When a custodial Member returns to the ECF prior to or on the 8th calendar day, the existing ECF TAR is still valid.
  - e. If a Partnership Member returns to an ECF after 8 calendar days, a new ECF TAR and all required attachments must be submitted (see initial TAR submission requirements described above according to facility type.)
  - f. NOTE: The ECF must notify Partnership when a Member is readmitted to the ECF. Claims will not be paid if the readmission is not appropriately reported to Partnership.
- D. Denials
- 1. Cases determined not to meet ECF admission criteria or continued stay criteria based on DHCS Title 22 regulations, CMS regulations, other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*, and the information available at the time of review, are managed as follows:
    - a. If the UM Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
    - b. Denials of medical necessity are determined only by the Partnership CMO/ Physician Designee.
    - c. UM staff will ensure the Member, provider, and facility are notified verbally and/or in writing as appropriate. Notice of Action letters will include the applicable appeal rights as described in policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions*.
- E. Criteria for Ending or Modifying an Active TAR
- 1. Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
    - a. Member's death (Partnership must be notified within 24 hours of Member expiring)
      - 1) If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable
      - 2) Notification of a Member's death should include whether the death occurred within the ECF or in an acute care facility.
    - b. Exhausted 7 calendar day bed hold
    - c. Discharge to other health insurance payor (e.g., Medicare)
    - d. Discharge to hospice care (see policy MCUP3020 Hospice Services for requirements)
    - e. Discharged to home or transfer to another ECF
    - f. Change in level of care (e.g. Custodial to Skilled or Skilled to Custodial)
  - 2. For all of the above, Partnership recommends that the ECF submits a Bed Hold/Change of Status Report form (Attachment A).
    - a. For all circumstances except death (which requires notification within 24 hours), a Bed Hold/Change of Status form (Attachment A) should be submitted within seven (7) days.
- F. Quality Monitoring and Review
- 1. The UM Nurse Coordinator assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies as requested.
  - 2. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue, the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.
- G. Policies for Other Services or Supports

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1. Facility Therapy Services
  - a. Federal Law states that “each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care.” In many cases, however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility’s per diem rate) and, therefore, are not separately reimbursable.
    - 1) Therapy services provided to the Member that are covered by the per diem rate include, but are not limited to:
      - a) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician’s order
      - b) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
      - c) Care to prevent formation and progression of decubiti, contractures and deformities, including:
        - i. Changing position of bedfast and chairfast recipients
        - ii. Encouraging and assisting in self-care and activities of daily living
        - iii. Maintaining proper body alignment and joint movement to prevent contractures and deformities
2. Durable Medical Equipment (DME)
  - a. For requests for DME for residents residing in an ECF, it is the responsibility of the facility and its staff to meet the patient’s needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter [\(APL\) 15-018](#) of July 9, 2015, *Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components*, regarding provision of wheel chairs for Members residing in a skilled nursing facility.
  - b. The ECF is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.
3. Transportation
  - a. For all transportation needs, please refer to Partnership’s policy MPTP2501 Transportation Policy for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
4. Enhanced Care Management / Community Supports
  - a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM) for further details.
  - b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people’s lives that influence their health. For Members currently in a LTC setting who may benefit from Community Supports, please refer to Partnership policy MPAP7003 CalAIM Community Supports (CS)
5. Partnership has a Long-Term Services and Supports (LTSS) Liaison who assists facilities in addressing claims and payment inquiries and coordinates support for LTSS providers to best meet Members’ needs. Contact information for Partnership’s LTSS Liaison can be found on this webpage: <https://www.partnershiphp.org/Providers/Medi-Cal/Pages/DHCS%20Directed-Payments-Programs.aspx>

<b>Guideline/Procedure Number:</b> MCUG3038 (previously UG100338 and MCUP3105)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Guideline/Procedure Title:</b> Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> 11/13/2025 <b>Last Review Date:</b> 11/13/2024	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>		<input checked="" type="checkbox"/> <b>Medi-Cal</b>

**VII. REFERENCES:**

- A. Medi-Cal Guidelines/Provider Manual:
  - 1. Subacute Care Programs: Level of Care for Adults and Children ([subacut lev](#))
  - 2. Subacute Care Programs: Adult ([subacute adu](#))
  - 3. Subacute Care Programs: Pediatric ([subacut ped](#))
  - 4. Leave of Absence, Bed Hold, and Room and Board ([leave](#))
  - 5. TAR for Long Term Care: 20-1 Form ([tar ltc](#))
  - 6. TAR for Long Term Care (Form 20-1): Inpatient Services ([tar ltc ip](#))
  - 7. TAR Completion for Long Term Care ([tar comp ltc](#))
- B. InterQual® criteria
- C. Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services
- D. Title 22 California Code of Regulations (CCR) Sections [51003\(e\)](#), [51118](#), [51120](#), [51120.5](#), [51121](#), [51124](#), [51124.5](#), [51124.6](#), [51134](#), [51335](#), [51335.5](#), [51335.6](#), [51321\(h\)](#), [51535](#), [51535.1](#), [72520](#)
- E. Title 42 Code of Federal Regulations (CFR) Section [483.15e](#)
- F. Welfare and Institutions Code (WIC) §[14132.25](#)
- G. Health and Safety Code (HSC) § [1373.96](#)
- H. DHCS All Plan Letter ([APL 15-018](#)) dated 07/09/2015 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components
- I. All County Welfare Director’s Letter [ACWD 25-02](#) 2025 Statewide Average Private Pay Rate for Nursing Facility Services (01/22/2025)
- J. DHCS [APL 24-009](#) Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/16/2024)
- K. DHCS [APL 24-010](#) Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/16/2024)
- L. [DHCS Subacute Care Program](#) and [Manual of Criteria R-15-98E](#)
- M. California Department of Public Health Healthcare-Associated Infections Program: [Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California Skilled Nursing Facilities \(2025 – 2026\)](#)

**VIII. DISTRIBUTION:**

- N. Partnership Department Directors
- O. Partnership Provider Manual

**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:** Chief Health Services Officer

**X. REVISION DATES:** 06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; \*10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24; 11/13/24; 01/14/26

\*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee’s meeting date.

**PREVIOUSLY APPLIED TO:**

MCUP3105 - Coordination of Services for Members Requiring Long Term Care

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<b>Guideline/Procedure Number:</b> MCUG3038 (previously UG100338 and MCUP3105)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
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<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>		<input checked="" type="checkbox"/> <b>Medi-Cal</b>

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.