PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="5">Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="5">Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="4">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 11/13/2025
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td><td></td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="4">Approval Date: 11/13/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3051 – Long Term Care SSI Regulation
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
E. MCCP2016 – Transportation Guidelines for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
F. MPQP1016 – Potential Quality Issue Investigation and Resolution
G. MCRP4068 – Medical Benefit Medication TAR Policy
H. MCUP3142 – CalAIM Community Supports
I. MCCP2032 – CalAIM Enhanced Care Management (ECM)
J. MPPR210 – Long Term Support Services Liaison

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Custodial Care: Non-medical care that helps Members with their daily basic care such as eating, bathing, and/or mobility.
B. Intermediate Care Facility (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
C. Long Term Care (LTC) Facility: A health facility that provides rehabilitative, restorative and/or on-going skilled nursing care to patients in need of assistance with activities of daily living (ADLs).
D. Skilled Nursing Facilities (SNFs): A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.
E. Subacute Care Facilities: Facilities with a level of care that is less intensive than acute care, but is more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
F. Subacute Contracting Unit: (SCU)

IV. ATTACHMENTS:

A. Bed Hold & Change of Status Report form

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)		**Lead Department: Health Services**
Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: 11/13/2025** **Last Review Date: 11/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Long Term Care (LTC) facilities for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Long Term Care Facilities

1. Partnership ensures access to licensed long-term care facilities, irrespective of location in or out-of-network, to Members in need of long-term care services. These facilities may include:
   a. Skilled Nursing Facilities (SNF) as defined in III.D
   b. Subacute Care Facilities (pediatric and adult) as defined in III.E.
   c. Intermediate Care Facilities (ICF) as defined in III.B.
2. A Member in need of long term 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. 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). These Title 22 Medi-Cal guidelines are used to determine the medical necessity for continued placement in a long-term care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended. Classification categories include the following:
   a. 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 be short term, where there is potential for the Member eventually being transferred to a lower level of care; or 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.
   b. Short Term Care: The Member may need a short term stay for a skilled nursing care need or short term rehab services and expected to return to his/her previous living arrangement or alternate level of care.
   c. Long Term Care: When a Member is admitted for custodial care, the TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments.
4. The choice of a long term care facility for a patient is a decision that should include consideration of the following:
   a. If the facility is a licensed Medi-Cal provider
   b. If the facility is contracted with Partnership
   c. If there are beds available
   d. If more than one choice is available, the family's choice of facility
   e. Benefit coverage limitations
5. A Long Term Care (LTC) facility must be a licensed institution (other than a hospital).
   a. An LTC facility must meet all of the following requirements:
      1) It must be qualified as a provider of services under Medi-Cal
      2) It must maintain on the premises all facilities necessary for medical care and treatment

3) It must provide such services under the supervision of physicians
4) It must provide services given by or supervised by a registered nurse AND
5) It must keep medical records on all patients

b. For Members approved for subacute services, Partnership verifies 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.

B. Short Term Skilled Nursing and Rehab Programs

1. Skilled level nursing is a covered level of care for Partnership's Members. Usually this level of care is short term and follows hospitalization at an acute care facility during the acute rehabilitation stage of treatment for an illness or injury.
   a. Admission to a skilled nursing facility must be coordinated with a contracted, Medi-Cal licensed facility by the discharge planner. If the Member is not currently confined, or the hospital discharge planner is unavailable, the Partnership Nurse Coordinator is the appropriate contact for referral to a skilled nursing level facility.
   b. The attending physician should also be aware that a history and physical are needed by the skilled nursing facility that is accepting the Member. Orders are generally accepted over the telephone for an immediate placement and a written history and physical must then be completed and sent to the accepting facility.
2. Specialized Rehabilitative Services
   a. Specialized rehabilitative services in skilled nursing facilities shall be covered in accordance with the standards of medical necessity. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either:
      1) A sustained higher level of self-care and discharge to home or
      2) A lower level of care
   b. Specialized rehabilitation service shall be covered contingent upon compliance with the following requirements:
      1) The services shall be ordered by the beneficiary's attending physician.
      2) The physician's signed order, specifying the care to be given, shall be on the beneficiary's chart.
      3) A copy of the order shall be made available for departmental review upon request.
   c. The services require prior authorization by the Partnership Nurse Coordinator prior to admission to a skilled nursing facility. The authorization request shall be accompanied by a treatment plan, signed by the attending physician, which shall include the following:
      1) Principal and significant diagnoses
      2) Prognosis
      3) Date of onset of illness or injury
      4) Specific type, number, and frequency of services to be performed by each discipline
      5) Therapeutic goals of the service provided by each discipline and anticipated duration of treatment
      6) Extent of and benefits or improvements demonstrated by any previous provision of physical therapy, occupational therapy, speech pathology or respiratory services
   d. Professional therapy necessary to establish maintenance program services under treatment programs not requiring the skills of a qualified therapist shall not be separately payable or authorized.

C. Admission to a LTC Facility

1. In alignment with Manual of Criteria R-15-98E, an initial Treatment Authorization Request (TAR) is required with each admission. A LTC Treatment Authorization Request (TAR) is required when

the Member:

a. Is a new admission to the facility
b. Has exhausted his/her Medicare benefits
c. Medicare or other insurance denies LTC
d. Is readmitted to LTC from an acute care hospital or did not return to the LTC facility on or before day eight (8) of "bed hold days"
e. Returns to the LTC facility from an approved leave of absence beyond the approved return date
f. Is newly eligible with Partnership while residing in the LTC facility
g. Changes level of care (e.g. ICF level to SNF level, SNF to ICF level of care, SNF to Subacute)

2. The physician/ facility submits the TAR to the Partnership UM Department with the following documentation:
   a. A completed Pre-admission Screening and/or a Preadmission Screening and Resident Review (PASRR) form indicating appropriateness for placement
   b. The Minimum Data Set (MDS) and relevant medical record documentation supporting the medical necessity for the level of care requested which must have been completed within the last 90 calendar days to request for custodial care or re-authorization
   c. A Medicare or other insurance denial, if applicable
3. A UM Nurse Coordinator reviews the request for medical necessity and level of care.
   a. Cases not meeting criteria for medical necessity are referred to one of the Medical Directors for review and determination.
   b. Upon determination of medical necessity, an approval 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.
   c. Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what Partnership actually approves.
   d. The facility is responsible for verifying the Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.
   e. Acute Care to Long Term Care Facility
      The transfer must be coordinated by the hospital discharge planner or case worker to Partnership inpatient concurrent review nurse prior to admission to the LTC facility. The hospital discharge planner or case worker will notify the Partnership inpatient concurrent review nurse when the Member needs to be transferred to a LTC facility.
      1) The Partnership inpatient concurrent review nurse will discuss the case with the Partnership Nurse Coordinator. If the transfer meets the Partnership guidelines, verbal approval is given for admission to the skilled nursing facility.
      2) If a Member is capped to a hospital, the discharge planner at the hospital will directly notify the Partnership Nurse Coordinator to initiate a referral to a skilled facility.
   f. Admission from Home to Long Term Care Facility
      1) A LTC facility is required to notify Partnership before any elective admission. Prior authorization is required for all elective admissions from home.
      2) The following information must be submitted with the prior authorization request via TAR:
         a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in a long term care facility and the physician's certification that placement in the long term care facility is the appropriate level of care for the Member.
         b) If placement follows an acute hospital stay within the past 30 calendar days, please submit the hospital history and physical and discharge summary.
         c) If the Member has not been confined in an acute care hospital within the past

30 calendar days, please submit the Primary Care Provider's progress notes for the past six (6) months.

d) 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 to the facility.

g. Admissions on Weekends and Outside normal business hours
   1) For an admission to LTC facility on the weekend or outside normal business hours, facility is to contact Partnership as soon as possible to identify the Partnership Member, reason for admission, and name of facility.
   2) 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.

h. Transfer to an Acute Care Facility
   1) The transfer of a Member to an acute care facility must be reported through the Bed Hold & Change of Status Report form (Attachment A) weekly. When appropriate, the Partnership Nurse Coordinator places the Member in a "bed hold" status for up to 7 calendar days. (see VI.G.4)
   2) The LTC facility must notify Partnership when the Member is readmitted to the LTC facility. Claims will not be paid if the readmission is not appropriately reported to Partnership.

i. Discharge or Death
   1) All discharges or deaths must be reported on a weekly basis. (Attachment A "Bed Hold & Change of Status Report" form is recommended for reporting.)
   2) Notification of a Member's death should include whether the death occurred within the LTC or in an acute care facility.

j. Medicare/Medi-Cal Members
   1) Members with both Medi-Cal and Medicare coverage become the financial responsibility of Partnership when the Member has exhausted their Medicare skilled days benefit.
   2) The SNF must submit the Medicare denial letter showing non-coverage of services to Partnership along with a completed TAR and required medical documentation for review. Partnership's Nurse Coordinator reviews the case to determine the medical necessity of continued authorization.
   3) Note: Partnership follows Title 22 criteria for admission and continuing care for LTC facilities.

D. Denials and Coordination of Care
   1. Cases determined to not meet LTC guidelines based on Title 22 Medi-Cal Guidelines and the information available at the time of review, are managed as follows:
      a. If the 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. The Nurse Coordinator contacts the attending physician to discuss concerns regarding patient's acuity, treatment plan or length of stay (LOS), or to obtain any additional pertinent information that might assist with the level of care determination.
      c. Denials of medical necessity are determined only by the Partnership Chief Medical Officer (CMO) or Physician Designee.
      d. UM staff ensures the Member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights.

E. Continuing Care Determinations
   1. Extensions of stay in SNF 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 for newly admitted Members who may be eligible to return home.

2. 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 four months. Extensions are based on the same criteria as initial authorizations.
3. When a Member is admitted for custodial care, a TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

F. Continuity of Care Requirements

1. Effective January 1, 2024, and through June 30, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, Partnership will automatically provide 12 months of continuity of care for the Subacute Care Facility placement. Automatic continuity of care means that if the Member is currently residing in a Subacute Care Facility, they do not have to request continuity of care to continue to reside in that facility. While Members must meet medical necessity criteria for adult or pediatric subacute care services, continuity of care must be automatically applied.
   a. Consistent with Health and Safety Code section 1373.96, application of automatic continuity of care allows for the completion of covered services provided by a nonparticipating provider to a newly covered Partnership Member who, at the time that coverage became effective, was receiving services from that provider, irrespective of contracting status with Partnership.
   b. Members are allowed to stay in the same Subacute Care Facility, irrespective of location in or out-of-network, under continuity of care only if all of the following applies:
      1) The facility is contracted or actively in the process of being contracted by DHCS SCU.
      2) The facility is enrolled and licensed by the California Department of Public Health (CDPH)
      3) The facility is enrolled as a Medi-Cal Provider
      4) The Subacute Care Facility and Partnership agree to payment rates that meet state statutory requirements; and
      5) The facility meets Partnership's applicable professional standards and has no disqualifying quality-of-care issues.
   c. Partnership will determine if a Member is eligible for automatic continuity of care before the transition by identifying the Member's Subacute Care Facility residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or provider. A pre-existing relationship means that the Member has resided in the Subacute Care Facility at some point during the 12 months prior to the date of the Member's enrollment with Partnership.
   d. Following their initial 12-month automatic continuity of care period, a Member may request an additional 12 months of continuity of care, following the process established by APL 23-022, "Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023."
   e. A Member newly enrolling with Partnership and residing in a Subacute Care Facility on or after July 1, 2024, does not receive automatic continuity of care and must instead request continuity of care following the process established by APL 23-022.
2. A Member residing in a SNF who newly enrolls with Partnership on or after July 1, 2023 does not receive automatic continuity of care and must request continuity of care following the process established by APL 23-022.

G. Monitoring and Review

1. 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.

2. The Nurse Coordinator also assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies.

H. TAR Submission Requirements:
The authorization request shall be initiated by the facility with all required attachments as noted below. TAR should be submitted within 15 business days from the date of service. (Note that the TAR must also be submitted within 60 calendar days from the date that the Member established eligibility with Partnership.)

1. Initial TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
   c. Medicare or other Insurance denial letter (if applicable)
   d. Minimum Data Set (MDS)
2. Continued Care with a new TAR must include the following:
   a. Completed new TAR form
   b. Current MDS (or most recent quarterly MDS)
   c. Social Services notes and evaluation
3. Post-service Retrospective TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal LTC Facility Admission and Discharge Notification form)
   c. PASSR (Preadmission Screening and Resident Review Medicaid form)
   d. Minimum Data Set (MDS)
   e. Medicare or other health coverage denial letter (as applicable)
   f. Social Services notes and evaluation
4. Bed hold TAR (When a Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence)
   a. Bed hold TARs must include the following:
      1) Doctor's order
      2) Completed new TAR
   b. 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.
   c. When a Member returns to the LTC facility on the 8th calendar day, the current TAR is still valid.
   d. If a Partnership Member returns to a an LTC facility after 8 calendar days, a new TAR and all required attachments must be submitted (see VI.H.1. TAR Submission Requirements, Initial TAR).
5. Short Term TAR (Less than 90 calendar days in a LTC facility) must include the following:
   a. Doctor's order
   b. Completed new TAR form
   c. Medicare or other health coverage denial letter (as applicable)
   d. Eligibility must be No Other Insurance

I. Criteria for Ending or Modifying an Existing TAR
With written or electronic (via Partnership ePortal) notification, Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:

1. Member's death
2. Exhausted 7 calendar day bed hold

3. Discharge to Medicare, Health Maintenance Organization (HMO) or other insurance bed
4. Discharge to hospice care
5. Discharged to home or transfer to other LTC facility

J. Procedures for Discharge from LTC Facilities
1. Discharge summary should be sent to the Member's PCP upon discharge.
2. Day of Discharge or Death Same as Day of Admission Reimbursement Policy
   a. When a patient receiving skilled nursing or intermediate care expires or is discharged from a LTC facility, the facility must notify Partnership via the Bed Hold & Change of Status Report form (Attachment A).
   b. 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.
3. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in a LTC facility, 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 patients residing in a skilled nursing facility.
   b. The LTC facility 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.

K. Policies for Other Services or Supports
1. Facility Therapy Services
   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.
   a. Therapy services provide to the recipient that are covered by the per diem rate include, but are not limited to:
      1) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
      2) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
      3) Care to prevent formation and progression of decubiti, contractures and deformities, including:
         a) Changing position of bedfast and chairfast recipients
         b) Encouraging and assisting in self-care and activities of daily living
         c) Maintaining proper body alignment and joint movement to prevent contractures and deformities
2. Transportation
   a. For all transportation needs, please refer to Partnership's policy MCCP2016 Transportation Guidelines for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
3. 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 MCCP2032 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 MCUP3142 CalAIM Community Supports (CS)

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual: Subacute Care Programs: Level of Care for Adults and Children (*subacut lev*); Subacute Care Programs: Adult *(subacute adu);* Subacute Care Programs: Pediatric (*subacut ped*); Leave of Absence, Bed Hold, and Room and Board *(leave)*
B. InterQual® criteria
C. 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 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 97-07 1997 Statewide Average Private Pay Rate (APPR) for Nursing Facility Services (02/27/1997)
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (03/14/2023)
K. DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023. (08/15/2023)
L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023)
M. DHCS Subacute Care Program and Manual of Criteria R-15-98E

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. 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

*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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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.