

<b>POLICY AND PROCEDURE</b>	
<b>Policy # and TITLE:</b> UM91 Subacute Facilities	
<b>Primary Policy owner:</b> Utilization Management	<b>POLICY #:</b> UM91
<b>Impacted/Secondary policy owner:</b>	
1) <input type="checkbox"/> All Departments 2) <input type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input checked="" type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Care Management (CM) 5) <input checked="" type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input checked="" type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input type="checkbox"/> Pharmacy (PH) 17) <input checked="" type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input checked="" type="checkbox"/> Medical Management (MM)
<b>PRODUCT TYPE:</b> <input checked="" type="checkbox"/> Medi-Cal	<b>Supersedes Policy Number:</b> N/A

**I. PURPOSE**

To outline Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”)’s responsibility to provide medically necessary services for Health Plan members residing in a Subacute facility.

**II. POLICY**

A. Health Plan is responsible for authorizing and covering medically necessary adult and pediatric subacute care services (provided in both freestanding and hospital-based), including:

1. Facility services,
  2. Professional services,
  3. Ancillary services, and
  4. The appropriate level of care coordination, including for carved-out Medi-Cal services.
- B. Health Plan ensures a Member that needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
1. Health Plan instructs non-DHCS contracted Subacute Care Facilities that they must contract with DHCS or be actively in the process of applying for a Medi-Cal Subacute Care Facility contract in order to receive payment.
- C. Health Plan is responsible for coordinating care and ensuring Members are placed in a subacute health care facility that provides the most appropriate level of care for the Member's medical needs.
- D. Health Plan is responsible for coordination of benefits with other health coverage (OHC) programs, recognizing OHC as primary, and Medi-Cal as the payer of last resort, in accordance with Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage.
- E. Health Plan is responsible for ensuring that Subacute care staff have training on benefits coordination, as described in Health Plan Policy PRO20 Provider Training and Education.
- F. Pharmacy services billed on a medical and/or institutional claim are reviewed in accordance with Health Plan Policies PH05 Prior Authorization Review and PH23 Submission of Pharmacy Benefit Prior Authorization & Claims.
- G. Health Plan is responsible for providing Population Health Management (PHM) services to Members residing in a Subacute facility in accordance with Health Plan Policies PHM01 Population Health Management, UM50 Community Supports, UM 87 Enhanced Care Management, and UM 88 Transitional Care Services, including:

1. Coordination of medically necessary drugs or medications on behalf of the Member,
  2. Basic Population Health Management,
  3. Transitional Care Services,
  4. Care Management Programs, and
  5. Community Supports
- H. Health Plan follows the minimum standards of medical necessity subacute level of care and eligibility to include:
1. For the adult subacute level of care medical necessity:
    - a. Physician visits are required at least twice weekly during the first month and a minimum of at least once a week thereafter,
    - b. Twenty-four-hour access to services available in a general acute care hospital,
    - c. The need for special medical equipment and supplies such as ventilator are in addition to those listed in Title 22 CCR, Section 515119(b), and
    - d. Twenty-four-hour nursing care by a registered nurse.
  2. Eligibility criteria to qualify for adult subacute level of care:
    - a. Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day.
    - b. Tracheostomy care with suctioning and room air mist or oxygen needed, and one of the six treatment procedures outlined in Appendix A of this policy.
    - c. Administration of any three of the six treatment procedures outlined in Appendix A of this policy.
  3. Health Plan follows the eligibility criteria for Pediatric Subacute care as follows:
    - a. Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours a day.
    - b. Tracheostomy care requires suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one the five (b thru f) treatment procedures outlined in Appendix A of this policy.

- c. Total parenteral nutrition of other intravenous nutritional support and one for the six (a through f) treatment procedures outlined in Appendix A of this policy.
  - d. Skilled nursing care in the administration of any three of the six (a through f) treatment procedures listed in attachment A to this policy.
  - e. Bi-phasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment of intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five (a through e) treatment procedures outlined in Appendix A of this policy, as well as care provided in Distinct-Part/Nursing Facilities Level B in acute care hospitals, or Free-Standing Nursing Facilities Level B who contract with DHCS.
- I. Health Plan members in acute care beds determined to be at the subacute level of care and requiring a subacute bed continue to receive authorization for acute care until placement in a subacute bed.
- 1. Health Plan Authorization Forms should appropriately identify whether a member needs subacute care services.
  - 2. Health Plan authorization request form aligns with requirements outlined in DHCS form 6200 and 6200A for adult and pediatric subacute services.
- J. Health Plan provides Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation to Members, including those residing in a Subacute facility, in accordance with APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, and Health Plan Policy UM 55: Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses.
- 1. This includes providing NEMT services if the Member is being transferred from an emergency room or acute care hospital to a Subacute facility, without prior authorization.

2. For covered services requiring recurring appointments, Health Plan provides authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months.
  - a. The Member must have an approved Physician Certification Statement form authorizing NEMT by the Provider.
- K. Health Plan allows the Member to return to the same subacute facility where they previously resided when an acute hospital admission interrupts their Subacute stay subject to medical necessity, in accordance with Medi-Cal leave of absence/bed hold policies.
  1. Health Plan ensures that the subacute facility notifies the member and/or the member's authorized representative in writing of their right to exercise the bed hold provision.
  2. Health Plan regularly reviews all bed hold denials.
  3. Health Plan ensures that the subacute facility staff are appropriately trained on LOA and bed hold requirements, including knowledge of the required clinical documentation to exercise these rights.
  4. If a subacute facility claims an exception from the bed hold regulations, or fails to comply with the requirements, Health Plan provides transition assistance and care coordination to ensure the member is placed in a new subacute facility.
  5. Readmission authorization is not necessary for recipients returning from a leave of absence (LOA) if there is a valid authorization covering the return date.
    - a. Health Plan does not require readmission authorization for a LOA, except for an overnight stay at a summer camp.
    - b. A physician signature is required for an LOA only when a member is participating in a summer camp for the developmentally disabled.
  6. A recipient's record maintained in an NF-A, NF-B, ICF/DD, ICF/DD-H or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
- L. A Member residing in a subacute facility and newly enrolling in Health Plan does not receive automatic continuity of care but may request

continuity of care in accordance with Health Plan Policy CM69  
Continuity of Care.

- M. If a member is unable to access continuity of care as requested, Health Plan provides the member or their authorized representative with a written Notice of Action of an adverse benefit determination in accordance with Health Plan policy UM07 Notification of Modification or Denial.
- N. Initial authorizations may be granted for up to one (1) year from date of admission.
- O. Health Plan may approve subsequent authorizations for a member who meets the criteria of prolonged care for one (1) year.
- P. A new assessment is considered complete if the member is seen in-person and/or by synchronous telehealth by a contracted provider, the provider has reviewed the member's current condition and has completed a new treatment plan including assessment of the services specified by the pre-transition TAR approval.
- Q. Approval for pediatric subacute care services cease once the member turns 21 years of age.
  - 1. Discharge planning to an adult subacute care facility must be completed at least two months prior to the member turning 21 years of age.
- R. A new assessment shall be completed as described in Section II.P of this Policy.
- S. Health Plan expedites Prior Authorization requests for members who are transitioning from an acute care hospital to a subacute care facility.
- T. Health Plan makes all authorization decisions in a timeframe appropriate for the nature of the member's condition, and within 72 hours after relevant information needed to make an authorization decision.
- U. Health Plan identifies an individual, or set of individuals, to serve as a liaison for the long-term Services and Supports (LTSS) Provider community.
  - 1. This role must serve as a single point of contact for the service providers in both Provider representative role will have access to subject matter experts for issues related to:

- a. Care transitions to best support the member's needs, and
    - b. Assist providers in addressing claims and payment inquiries.
    - c. Health Plan ensures that their contact information is provided to Network Providers and notifies them of any changes in the liaisons' assignment as expeditiously in order to ensure coordination of services offered to Members.
  2. Liaisons receive training on the full spectrum of rules and regulations pertaining to the services they are coordinating, including referral requirements and processes, care management and authorization processes
  3. The LTSS liaison is trained in:
    - a. The rules and regulations pertaining to Medi-Cal covered LTC services, including payment and coverage policies
    - b. Timely claims payment requirements
    - c. The provider dispute resolutions process, and related policies and procedures
    - d. Care management, coordination and care transition policies among the LTSS Provider community to best support Members' needs in relation to LTC services
    - e. Assisting facilities in addressing claims and payment inquiries
    - f. Disseminating their contract information to the plan's providers
    - g. Providers of changes to LTSS liaison assignment expeditiously to ensure coordination and services to members
    - h. Knowing the most appropriate internal plan resources to call on so the liaison can serve as the single point of contact for providers
  4. UM provides policies and procedures training in:
    - a. Authorizations and referrals
    - b. Care management
    - c. Care coordination
    - d. Care transitions
- V. Health Plan provides access to medically necessary dental services in accordance with Health Plan Policy UM 40: Dental Services.

- W. Health Plan is responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided.
- X. A system must be in place for Health Plan to collect quality assurance and improvement findings from CDPH and DHCS' SCU to include, but not limited to, survey deficiency results, site visit findings, and complaint findings.
- Y. Health Plan's comprehensive QAPI programs incorporate the following:
  - 1. Contracted Subacute Care Facility's QAPI programs, which must include five key elements identified by CMS.
  - 2. Claims data for Subacute Care Facility residents, including but not limited to emergency room visits, health care associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS- supplied WQIP data via template provided by DHCS on a quarterly basis.
  - 3. Mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan.
  - 4. Efforts supporting Member community integration.
  - 5. DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents.
- Z. Health Plan reports on LTC measures within the Managed Care Accountability Set (MCAS) of performance measures.
  - 1. This includes calculating the rates for each MCAS LTC measure for each Subacute Care Facility within the network for each reporting unit.
- AA. Health Plan monitors over/underutilization of ICF/DD Home services in accordance with Health Plan Policy UM 05: Over/underutilization of Services Monitoring.

### III. PROCEDURE

- A. Facility requests for authorization for SNF services must be submitted to Health Plan via Health Plan's provider portal at <https://www.hpsj.com/providers> or by sending an authorization request form by facsimile to the (209) 762-4702.
1. The authorization form must be filled out completely, including:
    - a. The members complete information, including name, health plan ID, address, date of birth and appointment date if known,
    - b. The servicing provider that the service is to be authorized to, including specialty, address, and phone number,
    - c. The ICD diagnosis for the treatment requested, and
    - d. The CPT/Procedure code and quantity being requested.
      - i. All DME requests must include the appropriate modifier.
    - e. Clinical documentation to support the need for the requested service(s).
  2. If the clinical information is either inadequate or not submitted validating the need for Subacute care, Health Plan's LTC staff reaches out and requests clinical information necessary to process the request.
- B. The authorization is processed in accordance with Health Plan Policy UM01 Authorization and Referral Process, UM02 UM50 Community Supports and this Policy.
1. The LTC nurse works with Case Manager (CM) in the Subacute care setting to ensure transfer of medical records to the facility, ensuring that care is not interrupted, and continued provision of all medical necessary covered services to the member enrolled with Health Plan.
    - a. Health Plan's LTC staff authorizes prior authorization requests for members transitioning from an acute care hospital in an expedited manner, requiring a response time of 72 hours, including weekends in accordance with Health Plan Policy UM01 Authorization and Referral Process.

2. The requestor includes a copy of the completed PASRR (Pre-admission Screening and Resident Review) with the Subacute authorization request.
    - a. The PASRR is required documentation prior to authorization of LTC services.
    - b. The PASRR is to be completed prior to placement in the Subacute Facility.
  3. All adverse determinations are completed in accordance with Health Plan Policy UM07 Notification to Members of Denial, Deferral, Modification, and Terminate Actions.
- C. Health Plan's LTC staff collaborates with nursing facility staff to ensure the member's:
1. Subacute needs are met,
  2. Targeted healthcare outcomes are achieved, and
  3. Transitions between settings are effectively coordinated.
- D. Transfer of a Member from the Subacute Facility to an acute hospital must be communicated to Health Plan's LTC staff, and include:
1. A bed hold request for not less than seven calendar days.
    - a. The LTC facility is responsible to ensure that a Member/ Member's authorized representative is informed regarding the right to exercise the bed hold provision.
- E. Health Plan's LTC staff coordinates discharge planning with the acute care facility to ensure the appropriate level of post-acute care and return to the originating Subacute facility if the discharge occurs within seven calendar days.
1. If the Member is ready for discharge for up to seven calendar days and the Subacute facility claims an exception under bed hold regulations or fails to comply with regulations regarding bed holds, Health Plan LTC staff provides transition assistance and care coordination to the new LTC facility.
  2. If the member is ready for discharge from the acute care facility at or beyond seven calendar days, the LTC staff coordinates

Member discharge planning to the previous Subacute facility or to a new Facility that meets the member's care needs.

- F. A member residing in a Subacute facility may request a leave of absence from the facility for personal reasons, such as visiting family or friends.
1. The member is entitled to 18 leave of absence days per calendar year, and may extend an additional 12 days.
- G. **Member Transitions:** Health Plan ensures care transitions from one level of care to another do not delay or interrupt any Medically Necessary services or care for the member transitioning to a nursing facility.
- H. Health Plan LTC staff, ECM or Complex Case Manager provides traditional care services (TCS) during all transitions:
1. Coordinate with facility discharge planner, case manager(s), or social worker(s) to provide case management .
  2. Assist Members or Member's parents, legal guardians, or authorized representatives by:
    - a. Evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and
    - b. Referrals and coordination with In-Home Support Services (IHSS), Community Supports (CSS), Long Term Support Services (LTSS), and other Home and Community-Based Services (HCBS).
  3. Maintain contractual requirements for Skilled Nursing Facilities to:
    - a. Share Minimum Data Set (MDS) Section Q, and
    - b. Health Plan's appropriate systems to import and store MDS Section Q data, and
    - c. Incorporate MDS Section Q data into transition assessments.
  4. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge.

5. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met.
6. Follow up with Members, Members' parents, legal guardians, or authorized representatives, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services in accordance with Health Plan Policy UM88 Transitional Care Services.

#### IV. ATTACHMENT(S)

- A. [Attachment A](#)
- B. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- C. [Glossary of Terms Link](#)
- D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

#### V. REFERENCES

- A. 22 Code of California Regulations (CCR) sections 51124.5, 51124.6, 51124.6, 51215.6, 51335.5, 51335.6, 51510, 51511, 72520(b)
- B. 28 CCR 1300.67.2.2(c)
- C. 42 Code of Federal Regulations (CFR) section 438.6(c), 483.15(e)
- D. DHCS Contract Exhibit A, Attachment III Section 3.3.15
- E. DHCS APL 13-003: Coordination of Benefits: Medicare and Medi-Cal
- F. DHCS APL 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses
- G. DHCS APL 22-027: Cost Avoidance and Post-Payment Recovery for Other Health Coverage
- H. 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
- I. DHCS APL 23-027: Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- J. DHCS contract Attachment III Section 4.3.11.C Transitional Care Services

- K. Health and Safety Code (H&S) sections 1367.01, 1367.09, 1373.96
- L. Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage
- M. Health Plan policy CM69 Continuity of Care
- N. Health Plan Policy PH05 Prior Authorization Review
- O. Health Plan Policy PH23 Submission of Pharmacy Benefit Prior Authorization & Claims
- P. Health Plan Policy PHM01 Population Health Management
- Q. Health Plan Policy PRO20 Provider Training and Education
- R. Health Plan Policy UM 01 Authorization and Referral Process
- S. Health Plan Policy UM 05 Over/underutilization of Services Monitoring
- T. Health Plan Policy UM 06 Medical Review Criteria
- U. Health Plan Policy UM 07 Notification to Members of Denial, Deferral, and Modification Actions
- V. Health Plan Policy UM 40 Dental Services
- W. Health Plan Policy UM50 Community Supports
- X. Health Plan Policy UM 87 Enhanced Care Management
- Y. Health Plan Policy UM 88 Transitional Care Services
- Z. Medi-Cal Manual of Criteria
- AA. Medi-Cal Provider Manual
- BB. Welfare and Institutions Code (W&I) section 14132.25, 14184.102(d), 14184.201(c)(2), 14186.3(c)(4), 14184.201(c)(2)51215.6, 51535, 51535.1, 72520

**VI. REVISION HISTORY**

*\*Version 001 as of 01/01/2023*

<b>Version*</b>	<b>Revision Summary</b>	<b>Date</b>
001	Update per LTC Deliverable Phase II regarding time frame for initial TARs and Reauthorizations	1/23/24
002	Update to align with March 2024 updated Medi-Cal Provider Manual for Adult and Subacute programs. Including medical necessity, eligibility, authorization and LOA (leave of absence) requirements	4/10/2024

003	Update to include Medi-Cal enrollment requirement of Subacute facilities per APL 23-027	6/18/2024
004	Updated to reflect 1 year approval period and remove 1/1/24 transition verbiage	8/29/2025
005	Revised the LTSS liaison information, updated policy to address DHCS MOR.0248	10/14/2025
<b>Initial Effective Date:</b> 1/1/2024		

**VII. Committee Review and Approval**

Committee Name	Version	Date
Compliance Committee	005	12/02/2025
<ul style="list-style-type: none"> <li>Privacy &amp; Security Oversight Committee (PSOC)</li> </ul>		
<ul style="list-style-type: none"> <li>Program Integrity Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Audits &amp; Oversight Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Policy Review</li> </ul>	003	08/21/2024
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> <li>Quality Operations Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Grievance</li> </ul>		

**VIII. REGULATORY AGENCY APPROVALS**

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	005	11/4/2025
Department of Managed Care (DMHC)			

**IX. Approval signature\***

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

\*Signatures are on file, will not be on the published copy

**Attachment A**

**Treatment procedures, Adult, includes:**

- A. Total parenteral nutrition
- B. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week
- C. Tube feeding (nasogastric or gastrostomy)
- D. Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
- E. Intravenous therapy involving:
  - 1. the continuous administration of a therapeutic agent, or
  - 2. the need for hydration, or
  - 3. frequent intermittent intravenous drug administration via a peripheral and/or central
  - 4. line (for example, with Heparin lock)
- F. Debridement, packing and medicated irrigation with or without whirlpool treatment.

**Treatment procedures, Pediatric, includes:**

- A. Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.
- B. Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.
- C. Peritoneal dialysis treatments requiring at least four exchanges every 24 hours.
- D. Tube feeding via nasogastric or gastrostomy tube.
- E. Other medical technologies are required continuously, which in the opinion of the attending physician and the Medi-Cal consultant require the services of a professional nurse.
- F. Bi-phasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures in (a) to (e).