Excerpt: 22 CCR § 51335

Title 22. Social Security
Division 3. Health Care Services
Subdivision 1. California Medical Assistance Program (Refs & Annos)
Chapter 3. Health Care Services
Article 4. Scope and Duration of Benefits
§ 51335. Skilled Nursing Facility Services.

Skilled nursing facility services necessary for the treatment of illness or injury, are covered subject to the following:

(a) Skilled nursing facility services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the skilled nursing facility is located. The authorization request shall be initiated by the facility and shall be signed by the attending physician.

(b) An initial Treatment Authorization Request shall be required for each admission.

(1) An initial authorization may be granted for periods up to one year from the date of admission.

(2) An approved initial Treatment Authorization Request shall be required prior to the transfer of a beneficiary between skilled nursing facilities.

(3) For Medicare/Medi-Cal covered services (crossover services) a request for authorization shall be received by the Medi-Cal consultant's office on or before the 20th calendar day of skilled nursing facility care. Medi-Cal shall not pay coinsurance for skilled nursing facility care unless an authorization request has been approved covering the 21st and subsequent days of skilled nursing facility care. When the authorization request is received by the Medi-Cal consultant's office after the 20th day of skilled nursing facility care, one day of coinsurance authorization shall be denied for each day the request is late.

(c) A request for reauthorization must be received by the appropriate Medi-Cal consultant on or before the first working day following the expiration of a current authorization. When the request is received by the Medi-Cal consultant later than the first working day after the previously authorized period, one day of authorization shall be denied for each day the request is late.

(1) Reauthorizations may be granted for periods up to one year.

(d) The Medi-Cal consultant shall deny an authorization request or reauthorization request or shall cancel any authorization or reauthorization in effect when services or placement are not appropriate to the needs of the patient (beneficiary).

(1) Where the reauthorization request is denied or an existing authorization is cancelled, the beneficiary shall be notified in writing of the Department's decision to deny ongoing services; the provider will be notified simultaneously. If the beneficiary does not agree with the Department's decision, the beneficiary has the right to request a fair hearing pursuant to section 51014.1 herein. If the beneficiary requests

a fair hearing within ten days of the date of the notice, the Department will institute aid paid pending the hearing decision pursuant to section 51014.2 herein.

(2) Medi-Cal consultants shall deny any initial authorization request if the skilled nursing facility is not participating in Medicare as a skilled nursing facility and the patient is qualified for skilled nursing facility care. Medicare benefits shall be utilized to their fullest extent; failure to utilize such benefits shall result in denial of Medi-Cal benefits under this section for the same period of time Medicare benefits would have been available. Exception to this rule may be made:

(A) When skilled nursing facility benefits are known to have been exhausted.

(B) When Medicare rejects skilled nursing facility level of care and the Medi-Cal consultant determines the medical necessity for skilled nursing facility care.

(C) When it can be determined that there are no skilled nursing facility care beds available in or near the community.

(e) The attending physician must recertify, at least every 60 days, the patient's need for continued care in accordance with the procedures specified by the Director. The attending physician must comply with this requirement prior to the start of the 60-day period of stay for which the patient is being recertified. The facility must present proof of this recertification at the time of billing for services rendered.

(f) Medi-Cal beneficiaries in the facility shall be visited by their attending physician no less often than once every 30 days for the first 90 days following admission. Subsequent to the 90th day, an alternative schedule of visits may be proposed, subject to approval by the Medi-Cal consultant. At no time, however, shall an alternative schedule of visits result in more than 60 days elapsing between physician visits.

(g) Services are not covered unless provided on the signed order of the physician responsible for the care of the patient.

(h) There shall be a periodic medical review, not less often than annually, of all beneficiaries receiving skilled nursing facility services by a medical review team as defined in section 50028.2.

(i) Leave of absence from skilled nursing facilities is reimbursed in accordance with section 51535 and is covered for the maximum number of days per calendar year as indicated below:

(1) Developmentally disabled patients: 73 days.

(2) Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic program approved and certified by a local mental health director: 30 days.

(3) All other patients: 18 days. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:

(A) The request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.

(B) At least five days inpatient care must be provided between each approved leave of absence.

(j) In order to qualify for skilled nursing facility services, a patient shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of section 51124, will assist in determining appropriate placement:

(1) Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician;

(2) Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the following conditions:

(A) A condition which needs therapeutic procedures. A condition such as the following may weigh in favor of nursing home placement.

1. Dressing of postsurgical wounds, decubiti, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require nursing home care.

2. Tracheostomy care, nasal catheter maintenance.

3. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.

4. Gastrostomy feeding or other tube feeding.

5. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.

6. Bladder and bowel training for incontinent patients.

(B) A condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home dependent on the se verity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home:

1. Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician.

2. Regular observation of skin for conditions such as decubiti, edema, color, and turgor.

3. Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician.

(C) The patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications. Nursing home placement may be necessary for reasons such as the following:

1. Injections administered during more than one nursing shift. If this is the only reason for nursing home placement, consideration should be given to

other therapeutic approaches, or the possibility of teaching the patient or a family member to give the injections.

2. Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented. Many medications are now self-administered on an PRN basis in residential care facilities.

3. Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision.

4. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.

(D) A physical or mental functional limitation.

1. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities.

a. Bedfast patients.

b. Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes.

c. Patients who are unable to feed themselves.

2. Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation), when such patients are severely incapacitated by mental illness or mental retardation.

The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to his mental condition.

a. The severity of unpredictability of the patient's behavior or emotional state.

b. The intensity of the care, treatment, services, or skilled observation that his condition requires and,

c. The physical environment of the facility, its equipment, and the qualifications of staff and,

d. The impact of the particular patient on other patients under care in the facility.

(3) The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

(k) Special program services for the mentally disordered (as defined in chapter 3, division 5, title 22) provided in skilled nursing facilities are covered when prior authorization has been granted by the Department for such services. Payment for these services will be made in accordance with Section 51511.1.

(l) A need for a special services program for the mentally disordered is not sufficient justification for a beneficiary to be placed in a skilled nursing facility. All beneficiaries admitted to skilled nursing facilities must meet the criteria found in paragraph (i) of this section.

(m) A need for a special services program for the developmentally disabled or mentally disordered is not sufficient justification for a beneficiary to be placed in a skilled nursing facility. All beneficiaries admitted to skilled nursing facilities must meet the criteria found in paragraph (j) of this section.

(n) The placement criteria established in Section 14091.21 of the Welfare and Institutions Code must be met except in either of the following circumstances:

(1) The beneficiary's physician and the discharge planner determine that the beneficiary requires short-term nursing facility care for postsurgical, rehabilitation, or therapy services which are curative rather than palliative in nature; or

(2) The beneficiary's attending physician certifies in the medical record that transfer to a freestanding nursing facility would cause specific physical or psychological harm to the beneficiary.