SUBACUTE CARE AUTHORIZATION POLICY AND BEST PRACTICES

This resource for Medi-Cal Managed Care Plans (MCPs) reiterates subacute care policy requirements for authorizing services and best practices when working with subacute care providers. The Department of Health Care Services (DHCS) wants to remind MCPs of the policy and best practices around subacute care operations that can help lessen the administrative burden for subacute care providers.

This resource is in response to provider concerns and confusion regarding working with MCPs around criteria for subacute care admissions, frequency of authorizations, use of revenue codes, and requiring additional documentation for authorizations. Below, MCPs can find policy and best practices on:

- Authorization Criteria and Medical Necessity
- Authorization Timelines
- Leave of Absence and Bed Holds
- Subacute Care Claims and Payments

As a general reminder, MCPs must ensure that LTSS liaisons are designated to work with subacute care providers and that they have have specific knowledge related to subacute care and how the services differ from skilled nursing facility (SNF) care, custodial care, or other types of long-term care. Helpful resources include:

- APL 24-010: Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- October 2024 Spotlight on Subacute Care slide deck
- SNF and Subacute Care Facility Carve-In: Resources for Managed Care Plans

Authorization Timelines and Criteria

Authorization Criteria and Medical Necessity

Policy

Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. MCPs must determine Medical Necessity for adult members consistent with the Medi-Cal Manual of Criteria following the definition in Title 22 Code of California Regulations (CCR) section 51124.5. Medical Necessity for pediatric members may be found in Title 22 CCR section 51124.6 with supplemental requirements cited in the Welfare and Institutions Code (W&I) section 14132.25. Language on authorization forms and policies and procedures must distinguish subacute care from skilled nursing and other types of long-term care services as well as eligibility criteria and treatment procedures.

Best Practices

- Most members requiring subacute care services need the facility care long-term. Authorization approvals and timeframes should consider the member's need for the services long-term.
- MCPs must ensure that providers have access to the information they need. MCPs may use provider portals to share the status on claims, referrals, and authorization with contracted providers. For non-contracted providers that do not have portal access, MCPs must ensure they have access to information through other mechanisms.
- Ensuring all LTSS liaison staff working with subacute care providers are aware of the authorization and medical necessity criteria as well as the differences between levels of care including subacute care, a SNF level of care, and custodial care (a requirement for MCPs), will help expedite authorizations and decrease provider confusion.
- MCPs must communicate requests for supporting documentation in a timely manner and facilitate communication with the facility regarding a change in the member's status.
- MCPs must make the authorization request process and timeframes easily understandable and readily available for providers.
- DHCS encourages MCPs to use the DHCS 6200 and 6200A forms or include similar elements to these forms in MCP authorization processes to ensure

authorization processes are seamless for providers. Requesting additional information beyond what is required in the 6200 and 6200A forms may be burdensome for providers.

Authorization Timelines

Policy

Per the updated LTC Provider Manual, initial treatment authorizations are required for each new adult and pediatric admission to a Subacute Care Facility. Initial authorizations and subsequent reauthorizations may be approved for up to **one year.**

Authorizations for Members transitioning from an acute care hospital to a Subacute Care Facility must be considered expedited and the MCP must provide their decision within 72 hours of the authorization request.

An expedited authorization decision may also be needed in cases in which following the standard timeframe for prior authorizations could seriously jeopardize the Member's life, health, or ability to maintain or regain maximum function.

For routine authorizations, MCPs must respond within five working days and make a decision within 14 calendar days from receipt of the authorization request. MCPs must provide its authorization decision as expeditiously as the Member's health condition requires.

Timely authorization decisions are required so that providers can meet MCP timely claims submission requirements. Adherence to authorization timelines is also necessary for timely claims and payments (see below).

Best Practices

- MCPs must have escalation processes in place for providers and/or members to escalate concerns when there are delays in authorizations, including providing the LTSS Liaison contact information.
- MCPs should consider creating and sharing retroactive authorization policies that allow providers more time to submit authorization requests.
- MCPs must ensure staff at facilities have clear understandings of timing and processes to request reauthorization for a resident whose existing authorization is nearing the end date.

Pediatric Supplemental Rehabilitation Therapy Services and Ventilator Weaning Services Authorization

Policy

Per APL 24-010, supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute care patients. A separate authorization is required for these services. Authorization may be approved for a maximum of three months. Subsequent reauthorizations may be approved for up to three months.

Best Practices

- Most members requiring subacute care services need the facility care long-term. Authorization approvals and timeframes should consider the member's need for the services long-term.

Leave of Absence and Bed Holds

Authorization Policies for Leave of Absences and Bed Holds

Policy

Per APL 24-010, MCPs must ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. MCPs must authorize up to 7 days per hospitalization.

Best Practices

- While MCPs may choose to require prior authorization for Leave of Absences or Bed Holds, MCPs must work closely with subacute care providers to ensure appropriate documentation is provided and that these policies are clear and easily accessible to providers.
- MCPs should communicate often about how to timely and accurately request authorizations or documentation needed for reimbursement when a prior authorization is not needed.
- If MCPs require prior authorization for Bed Holds, then they must provide the authorization decision in a timely manner and as expeditiously as the Member's health condition requires. An expedited authorization decision may be needed in cases in which following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life, health, or ability to maintain or regain

maximum function. Expedited authorizations may be required in many cases for Members receiving subacute care services, given their level of medical acuity.

- DHCS encourages MCPs to use automatic, retrospective or presumptive approvals of authorization requests for Bed Holds of 7 days or under.

Subacute Care Claims and Payments

Timely Claims and Payments

Policy

MCPs must pay timely in accordance with the prompt payment standards within their MCP Contract. This includes all Subacute Care Facilities that are Network providers and those that have an executed agreement with an MCP (i.e., letter of agreement, single case agreement).

MCPs must pay claims, or any portion of any claim, as soon as practicable but no later than 30 calendar days after receipt of the claim, and are subject to interest payments if failing to meet the standards.

DHCS requires MCPs to pay clean claims within 30 calendar days of receipt. MCPs are highly encouraged to remit claims and invoices in the same frequency (e.g., weekly, monthly) in which they are received.

MCPs must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt, and 99 percent of all clean claims from such practitioners' claims, within 90 days of the date of receipt. Please refer to APL 23-020, Requirements for Timely Payments of Claims, regarding requirements for MCPs related to timely payment of claims including Network Provider training requirements.

As a reminder, please ensure the MCP is referring to the most recent rates for Freestanding Pediatric Subacute and Distinct Part Pediatric Subacute in accordance with directed payment requirements in APL 24-010.

Best Practices

- MCPs responses to claims and payment inquiries from providers should be prompt to assist providers and help resolve issues. MCPs can use LTSS liaisons to help escalate provider inquiries around billing and payment.
- MCPs should explain specific reasons why a claim was denied or why there were rejections during the adjudication process.

- Shorter payment timeframes for clean claims can help support provider operations for subacute care. MCPs should be consistent in reviewing clean claims to support providers and ensure prompt payment processes.
- MCPs and providers should work collaboratively to ensure alignment in understanding claims requirements. MCPs could continue to offer trainings, office hours, and open-door outreach approaches for subacute care providers.
- MCPs may establish payment arrangements, such as caseload-based monthly payments made at the beginning of each month to support facilities that have a predictable number of Medi-Cal members residing in the facility. This practice can help support cash flow issues for subacute care facilities.