MEDI-CAL AUTHORIZATIONS FOR LONG-TERM CARE PROVIDERS

This quick reference guide can help long-term care (LTC) providers navigate the Medi-Cal authorization process for Skilled Nursing Facility (SNF), Subacute Care, and Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home services.

Authorization for Institutional LTC

Authorization is a process in which providers obtain approval from a Medi-Cal member's managed care plan (MCP) before providing a specific item, service, or medication. Every MCP has its own procedures and forms for handling authorization requests, so providers must understand and follow the specific processes for each of contracted MCP.

This document helps LTC providers by outlining common steps for authorization,

providing useful tips such as questions to ask MCPs, a checklist to support successful submissions, and a quick reference guide for LTC authorizations.

Step One: Submitting the Authorization Request

LTC authorization requests can typically be made through the MCP's online portal, by fax, or by phone. An authorization request form is required. This form details member and provider information, diagnosis, service information, requested coverage, the physician's order or signature, and proof of medical necessity, which may require additional documents. This information is important as it outlines how a member meets

Authorization Quick Checklist

The checklist below helps ensure a successful initial authorization request submission:

- Provider information is complete and accurate.
- Billing address is complete.
- Member's information is correct.
- Requested start date and timeframe are included.
- Updated physician's order is included.
- All required forms and attachments are included.

the medical necessity criteria which may also include the submission of additional documentation. The ICF/DD Home service authorization requires the clinical review and recommendation from the coordinating Regional Center.

Questions to ask MCP:

- What is the preferred method of submission?
- What additional documentation is required as a part of the authorization request (e.g., what are the common follow up or additional items requested from LTC providers)?
- What is the process for requesting urgent or emergency requests?
- What are the common reasons for LTC authorization denials?

Step Two: MCP Reviews the Authorization Request

The MCP reviews the request for completion and all required information. This often involves a clinical review by nurses who are familiar with clinical care and medical criteria guidelines. Note: Authorizations for members transitioning from an acute care hospital must be expedited, requiring a response time from the MCP of no greater than 72 hours, including on weekends.

Questions to ask MCP:

- When my authorization is approved, how and where will I get notified of the authorization's timeframe?
- When do I need to request a reauthorization, and how long before the current authorization expires should I request reauthorization?
- My authorization was denied. What is the process for appealing the decision? What additional documentation is required for the appeal?

Step Three: MCP Issues an Authorization Decision

MCPs should respond to and make a decision on authorization requests as quickly as the member's condition requires. For routine authorizations, they should respond within five working days and make a decision within 14 calendar days from receipt of the authorization request. For expedited authorizations, the MCP should make a decision within 72 hours of the authorization request. This includes authorizations for members who are transitioning from an acute care hospital to any setting. If the MCP denies the request, the LTC provider can appeal the decision.

Questions to ask MCP:

- How can I track my authorization request?
- If I have questions about an MCP follow-up or request for additional documentation or justification, who is the best point of contact at the MCP, and how should I reach out to them?
- How and when will I be notified of the authorization request decision?
- If I do not receive a response within the expected timeframe, who is the best point of contact at the MCP, and how should I follow up with them?

Additional Authorization Information

LTC Service Reauthorization

Reauthorization is the process of reviewing and approving continued services for members once the initial authorization expires. It usually happens before the initial authorization period ends. LTC providers should be aware of MCP timelines to prevent any gaps in member care.

Leave of Absences and Bed Hold Authorizations

MCPs can authorize up to seven days per hospitalization for a bed hold and up to 73 days per calendar year for a leave of absence. Some MCPs may require authorization for bed holds. No authorization is needed for a member returning from a leave of absence if there is a valid authorization covering the return date. For members in ICF/DD Homes, a physician signature is only required for a leave of absence if the member is attending a summer camp for the developmentally disabled.

Additional Therapy Authorizations

Therapy services needed to achieve or maintain maximum functioning are included in the SNF per diem rate. Therapy services outside the per diem rate may require authorization, and SNFs should check with MCPs on how they authorize these services. Refer to questions #33 and #34 in the SNF Carve-In FAQs.

For subacute care: Supplemental rehabilitation therapy services and ventilator weaning services are not included in the pediatric subacute per diem rate. A separate authorization is required. Refer to the Subacute Care Programs: Pediatric section of the LTC Provider Manual.

Questions and Resources

Questions about the LTC authorization process should be directed to the respective MCP LTSS liaison. LTC providers can find additional information in DHCS-published resources on each of the following webpages:

- Skilled Nursing Facility CalAIM Carve-In webpage
- Intermediate Care Facility for the Developmentally Disabled CalAIM Carve-In webpage
- Subacute Care CalAIM Carve-In webpage

Quick Reference: LTC Benefit Authorizations

The following table outlines authorization periods, medical necessity, additional requirements for SNF, subacute care, and ICF/DD Homes.

Requirements and Facility Type	Skilled Nursing Facilities	Subacute Care	ICF/DD Homes
Authorization Periods	Up to one year and reauthorized for up to one year, Title 22 Code of California Regulations (CCR) section 51335.	*For adult/pediatric subacute care services (both for services in the per diem rate and for services outside the per diem rate):* Up to six months and reauthorized for a period of up to six months, per Title 22 CCR section 51335.5 and 51335.6. *For pediatric supplemental rehabilitation therapy service and ventilator weaning services:* Up to three months and reauthorized for a period of up to three months, per Title 22 CCR section 51215.10 and 51215.11.	Up to two years for both initial authorizations and reauthorizations, per the Medi-Cal Provider Manual.

Requirements and Facility Type	Skilled Nursing Facilities	Subacute Care	ICF/DD Homes
Medical Necessity	Having a medical condition that needs visits by a physician at least every 60 days and constantly available skilled nursing services, consistent with criteria outlined in Title 22 CCR section 51335.	*For adult members*: Consistent with the Medi-Cal Manual of Criteria following the definition in Title 22 CCR section 51124.5. *For pediatric members*: Consistent with Title 22 CCR section 51124.6 and Welfare and Institutions Code (W&I) section 14132.25.	Consistent with definitions in Title 22 CCR section 51343, 51343.1, and 51343.2 and W&I section 4512. MCPs must utilize the determination and recommendation from the coordinating Regional Center and attending physician for a member's admission to or continued residency in an ICF/DD Home.

Requirements and Facility Type	Skilled Nursing Facilities	Subacute Care	ICF/DD Homes
Additional Requirements	The Preadmission Screening and Resident Review (PASRR) is required for SNF or subacute care placement, as nursing facilities will not admit members from hospitals without a completed PASRR.		ICF/DD Homes must submit the following to MCPs for initial authorizations and reauthorizations: » Certificate for Special Treatment Program Services form (HS-231) » MCP ICF/DD Authorization Request form, or a plan specific form with the same data elements » Medical Review/Prolonged Care Assessment (6013A) form *For authorization for ICF/DD-Nursing Home services only*: The ICF/DD Home must submit the member's Individual Support Plan (ISP).