51334 Intermediate Care Services

Intermediate care services are covered subject to thefollowing:

(a)

Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care. (1) An initial treatment authorization request shall be processed for each admission. (2) An initial authorization may be granted for up to one year from the date of admission.

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(b)

The 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 has expired, one day of authorization shall be denied for each day the reauthorization request is late. Reauthorizations may be granted for up to six months.

(c)

The Medi-Cal consultant shall deny any authorization request, reauthorization request, or shall cancel any authorization in effect when services or placement are not appropriate to the health needs of the patient. In the case of denial of a reauthorization request or cancellation of authorization, 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.

(d)

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 60-day period for which the patient is being recertified. The facility must present proof of this recertification at the time of billing for services rendered.

(e)

Prior to the transfer of a beneficiary between facilities, a new initial Treatment Authorization Request shall be initiated by the receiving facility and signed by the attending physician. No transfer shall be made unless approved in advance by the Medi-Cal consultant for the district where the receiving facility is located.

(f)

Medi-Cal beneficiaries in the facility shall be visited by their attending physicians no less often than every 60 days. 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 three months elapsing between physician visits.

(g)

There shall be a periodic medical review, not less often than annually, of all beneficiaries receiving intermediate care services by a Medical Review Team as defined in section 50028.2.

(h)

Leave of absence from intermediate care 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 and rehabilitative 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 three 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.

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(i)

Special program services for the mentally disordered (as defined in chapter 4, division 5, title 22 of the California Administrative Code) provided in intermediate care facilities are covered when prior authorization has been granted by the Department for such services. Payment for these services shall be made in accordance with section 51511.1.

(j)

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

(k)

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 an intermediate care facility. All beneficiaries admitted to intermediate care facilities

must meet the criteria found in paragraph (l) of this section.

(l)

In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. As a guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement: (1) The complexity of the patient's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs. (2) Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify. (3) Diet may be of a special type, but patient needs little or no assistance in feeding himself. (4) The patient may require minor assistance or supervision in personal care, such as in bathing or dressing. (5) The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence. (6) The patient may have some degree of vision, hearing or sensory loss. (7) The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc. (8) The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently. (9) The patient may be occasionally incontinent of urine; however, patient who is incontinent of bowels or

totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for himself. (10) The patient may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to himself or others.

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