Appendix 15 ▪ Level of Care Criteria: California Code of Regulations (CCR) Title 22[1] Sections 51118, 51120, 51124, 51334, and 51335.

§51118. Intermediate Care Facility

Intermediate care facility" means a facility which is licensed as such by the Department or is a hospital or skilled nursing facility which meets the standards specified in Section 51212 and has been certified by the Department for participation in the Medi-Cal program.

Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14110 and 14132, Welfare and Institutions Code.

§51120. Intermediate Care Services.

(a) Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:

(1) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.

(2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.

(3) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

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[1] California Code of Regulations, TITLE 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program, Chapter 3. Health Care Services,

Article 2. Definitions
§51118. Intermediate Care Facility
§51120. Intermediate Care Services
§51124. Skilled Nursing Facility Level of Care.

Article 4. Scope and Duration of Benefits
§51334. Intermediate Care Services
§51335. Skilled Nursing Facility Services.

(b) With respect to services furnished to individuals under age 65, intermediate care services may include services in a public institution (or distinct part thereof) for mentally retarded or persons with related conditions only if:

(1) The primary purpose of such institution (or distinct part thereof) is to provide a program of health or rehabilitative services for mentally retarded individuals and such institutions meet standards as may be prescribed by the United States Department of Health and Human Services.

(2) The mentally retarded individual with respect to whom a request for payment is made has been determined to need and is receiving active treatment under such a program.

(3) Payment for intermediate care services to any such institution (or distinct part thereof) will not be used to displace with Federal funds any non-Federal expenditures that are already being made for mentally retarded persons.

51124. Skilled Nursing Facility Level of Care.

(a) “Skilled Nursing facility level of care” means that level of care provided by a skilled nursing facility meeting the standards for participation as a provider under the Medi-Cal program as set forth in Section 51215 of this division.

(b) The skilled nursing facility level of care is the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses, or the equivalent thereof, as set forth in Section 51215.

(c) Skilled nursing care provided in participating skilled nursing facilities is the composite of necessary observation, assessment, judgment, supervision, documentation, and teaching of the patient and includes specific tasks and procedures.

(d) Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's orders,

and are either performed or supervised by a licensed registered nurse, a licensed vocational nurse or in the case of institutions for mentally retarded or distinct parts of institutions which are certified as skilled nursing facilities and providing care for mentally retarded patients, by a licensed psychiatric technician. A need for one or more skilled nursing procedures does not necessarily indicate a medical need for skilled nursing facility services. Rather, the need must be for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following: administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions; gastric tube or gastrostomy feedings; nasopharygeal aspiration; insertion or replacement of catheters; application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders; heat treatments which require observation by licensed personnel to evaluate the patient's progress; administration of medical gases under prescribed therapeutic regimen; and restorative nursing procedures which require the presence of a licensed nurse.

(e) Other health care services, such as physical, occupational or speech therapy, require specialized training for proper performance. The need for such therapies does not necessarily indicate a need for nursing facility services.

Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14108 and 14110, Welfare and Institutions Code.

§51334. Intermediate Care Services.

Intermediate care services are covered subject to the following:

(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.

(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.

(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.

Authority cited: Sections 10725, 14105, 14108, 14108.1 and 14124.5, Welfare and Institutions Code. Reference: Sections 10725, 14105, 14108, 14108.1, 14108.2, 14124.5 and 14132, Welfare and Institutions Code.

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 severity 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.

Authority cited: Sections 10725, 14105, 14108, 14108.1 and 14124.5, Welfare and Institutions Code. Reference: Sections 10725, 14091.21, 14105, 14108, 14108.1, 14108.2, 14124.5 and 14132, Welfare and Institutions Code; *Hudman v Kizer,* Sacramento County Superior Court Case No. 362172, and *Laguna Honda Hospital and Rehabilitation Center of the City and County of San Francisco v Kizer*, U.S. District Court, EDCA, No. CIV-S90-1239 MLS EM.