Policy:	GG.1803
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 09/05/2024*
Effective Date:	06/01/1998
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the requirements for reviewing and processing a Long-Term Care (LTC) Authorization and the criteria for a Member's admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric.

II. POLICY

A. The CalOptima Health Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric, pursuant to the Title 22, California Code of Regulations, sections 51335.5 and 51335.6 and the California Department of Health Care Services (DHCS) standard criteria for subacute programs.

B. The initial and reauthorization requests shall be initiated by the subacute facilities. For initial LTC authorizations, a subacute Facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima Health LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the subacute Facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active authorization.

   1. If a subacute Facility submits an LTC ARF after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima Health shall subject the authorization to a fifteen percent (15%) payment reduction.

C. CalOptima Health may decide, at its discretion, to perform an onsite authorization review to make a Medical Necessity determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and a thorough review of the medical orders, care plan, therapist treatment plan, the subacute Facility's multidisciplinary team notes, or other clinical data appropriate to support making the determination on the authorization request.

1. If a subacute Facility is designated for regular onsite authorization reviews, the subacute Facility shall notify CalOptima Health's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima Health LTC coverage. For re-authorizations of a continued stay at a subacute Facility designated for regular onsite authorization reviews, the Facility shall also submit Member information on the 21-Day List at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The completed LTC ARF and all necessary supporting documentation do not need to be sent to CalOptima Health LTSS Department at the same time as the submission of the 21-Day List. However, subacute facilities designated for regular onsite authorization reviews must have the completed ARF and all necessary supporting documentation ready for onsite review by the CalOptima Health Medical Case Manager on the day of the scheduled visit.

2. If a subacute Facility designated for regular onsite authorization reviews submits Member information on the 21-Day List after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima Health shall subject the authorization to a fifteen percent (15%) payment reduction.

D. CalOptima Health's approval of a facility's authorization request is subject to the facility's being licensed by the California Department of Public Health (CDPH), meeting acceptable quality standards, and its agreement to CalOptima Health contracted rates, in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facility Contracting.

E. CalOptima Health shall ensure that Members in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute facilities, and Intermediate Care Facilities.

F. CalOptima Health shall ensure continuity of care for Members residing in a Subacute Facility-Adult, or Subacute Facility-Pediatric, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

1. CoC ensures that a Member's Subacute Facility will not be changed for at least twelve (12) months while CalOptima Health works to bring the Subacute Facility into its network.

2. CalOptima Health will automatically provide twelve (12) months of CoC for the Subacute Facility of any Member residing in a Subacute Facility who is mandatorily enrolled into an MCP after January 1, 2024. Automatic CoC means that Members currently residing in a Subacute Facility do not have to request CoC to continue to reside in the Subacute Facility.

3. CalOptima Health will automatically initiate the CoC process prior to the Member's transition to CalOptima Health.

   a. CalOptima Health shall determine if Members are eligible for automatic CoC before the transition by identifying the Member's Subacute residency and pre-existing relationship through historical utilization data or documentation provided by the Department of Health Care Services (DHCS), such as fee for service utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS.

   b. While Members must meet medical necessity criteria for Subacute services, CoC must be automatically applied. Medical necessity is determined by documentation reflecting current

care needs; however, if documentation is lacking, CalOptima Health shall request additional supporting documents to substantiate medical necessity.

4. CalOptima Health will ensure CoC for Members in a Subacute Facility by honoring treatment authorization requests (TAR) approved by DHCS for the Member enrolled into the MCP.

G. CalOptima Health may grant the initial authorization and reauthorization requests for six (6) months at a time.

H. For supplemental rehabilitation therapy and ventilator weaning services for a pediatric Member in a Subacute Facility, the Subacute Facility must submit a separate authorization request to the LTSS Department.

I. Effective January 1, 2024, CalOptima Health will provide all Medically Necessary Covered Services for Members residing in a Subacute Facility, including dental services, professional services, ancillary services, transportation services, and standing referrals, in accordance with CalOptima Health Policies GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center, GG.1504: Dental Services, GG.1505: Transportation: Emergency and Non-Emergency Medical, and GG.1508: Authorization and Processing of Referrals.

J. CalOptima Health will provide access to covered Medically Necessary behavioral health care services, in accordance with CalOptima Health Policies GG.1900: Behavioral Health Services and MA.7020: Behavioral Health Services.

K. CalOptima Health will ensure timely provision of access standards, including appropriate clinical timeframes, standards for timely specialty appointments, shortening or expanding timeframes, and arranging timely appointments with a provider shortage, in accordance with GG.1600: Access and Availability Standards.

L. CalOptima Health will ensure access for disabled Members pursuant to the Americans with Disabilities Act of 1990, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

M. CalOptima Health will provide Medically Necessary services through Out-of-Network Providers, including allowing access for the completion of covered services by an Out-of-Network Provider or terminated provider, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

N. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services, or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one (1) of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet Medical Necessity and results in a denial. The CalOptima Health Utilization Management Department will issue the Notice of Action (NOA) to the Subacute Facility which includes information on a Member's appeal rights. The NOA shall remain valid until a change of Member's condition is apparent and the Subacute Facility has

submitted a new request with additional medical documentation that substantiates Medical Necessity.

O. Leave of Absence and Bed Holds

1. CalOptima Health shall cover the stay when Members transfer from a Subacute Facility to any acute care hospital setting and then require return to a Subacute Facility in accordance with CalOptima Health Policy GG.1810: Bed Hold, Long Term Care.

2. CalOptima Health shall cover a leave of absence (LOA) in accordance with CalOptima Health Policy GG.1811: Leave of Absence, Long Term Care.

   a. If the Member does not wish to return to the same Subacute Facility following an LOA or approved bed hold period, CalOptima Health shall provide care coordination and transition support, to assist the Member to identify another Subacute Facility within the CalOptima Health, Health Network.

   b. CalOptima Health will take the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care.

P. CalOptima Health shall maintain a set of individuals as part of the CalOptima Health Provider Relations Department to serve as the liaison for LTC facilities.

1. Liaisons shall receive training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, provider resolution policies and procedures, and care management coordination and transition policies.

2. LTSS liaisons shall assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS provider community to best support Member's needs.

3. CalOptima Health shall identify these individuals and disseminate their contact information to relevant network providers, including Skilled Nursing Facilities (SNFs) that are within the network.

III. PROCEDURE

A. New admission for subacute facilities that are not assigned for regular onsite authorization reviews: The subacute Facility shall submit to the CalOptima Health LTSS Department the following within twenty-one (21) calendar days after a Member's admission:

1. Completed LTC ARF (Sections I through V);

2. If the Preadmission Screening and Resident Review (PASRR) Level I Screening is positive, a copy of the Preadmission Screening and Resident Review (PASRR) Level II Screening Document;

3. Medicare, Facility, or other insurance denial, if applicable;

4. Minimum Data Set (MDS), if available, and sufficient chart documentation to support the Medical Necessity for the level of care requested; and

5. Completed DHCS 6200-A form, Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program, or the DHCS 6200 Form, Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program.

B. For new admission at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

1. Notify CalOptima Health's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima Health LTC coverage.

2. Prepare the documents listed in Section III.A. of this Policy for review by the CalOptima Health onsite medical case manager during the scheduled onsite review appointment.

C. Reauthorization for subacute facilities that are not assigned for regular onsite authorization reviews shall submit to the CalOptima Health LTC Authorization Unit:

1. A completed LTC ARF (Sections I, III [as applicable] and IV), which shall be submitted prior to the expiration of the active LTC ARF, and may be submitted up to thirty (30) calendar days prior to expiration of the active LTC ARF;

2. The DHCS 6200-A Form, or the DHCS 6200 Form, as appropriate;

3. A detailed summary of acute care hospitalizations for the Member during the previous authorization period;

4. Sufficient documentation to determine the level of care and justify a continued stay; and

5. A copy of the weekly physician progress notes covering the month prior to the LTC ARF submission.

D. For reauthorization at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

1. Notify CalOptima Health's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, at least twenty-four (24) hours prior to the expiration of the active authorization.

2. Prepare the documents listed in Section III.C. of this Policy for review by the CalOptima Health onsite medical case manager during the scheduled onsite review appointment.

E. If the CalOptima Health Medical Director, or authorized physician designee, denies or modifies the LTC ARF, the CalOptima Health LTSS Department shall notify the Facility and the Member, or Member's Authorized Representative in accordance with CalOptima Health Policy GG.1510: Member Appeals Process.

F. Upon the receipt of an ARF modification, or denial, the Subacute Facility may file an appeal, or complaint, in accordance with CalOptima Health Policy GG.1510: Member Appeals Process.

G. Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

1. The Subacute Facility-Pediatric shall submit the initial authorization request to the CalOptima Health LTSS Department within ten (10) business days of the development of a treatment plan.

2. For supplemental rehabilitation therapy, the Subacute Facility-Pediatric shall:

    a. Complete LTC ARF (Sections I through V);

    b. Specify type, number, and frequency of direct therapy services to be performed by, or under the supervision of, the therapist;

    c. State the therapeutic goals of the services provided by each discipline and anticipated duration of treatment; and

    d. Provide the attending physician's order and evaluation report.

3. For ventilator weaning, the Subacute Facility-Pediatric shall

    a. Complete LTC ARF (Sections I through V);

    b. Clearly state "Ventilator Weaning;" and

    c. Provide the attending physician's order and evaluation report.

H. If the LTC ARF and required documents are incomplete, the CalOptima Health LTSS Department shall delay the approval process and return the incomplete LTC ARF and attachments to the subacute Facility for review and resubmission completed documentation, including any additional clinical documents. CalOptima Health's LTSS Department will verbally notify the Facility within twenty-four (24) hours of decision to delay. The subacute Facility shall resubmit the LTC ARF before the end of fourteen (14) calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial. When unable to make a decision, the CalOptima Health LTSS Department will document the need for additional information, what information is needed, and that the subacute Facility will have fourteen (14) calendar days from the presentation of the ARF to provide the documents in the CalOptima Health Medical Record system.

I. If, within fourteen (14) calendar days after CalOptima Health's return of an incomplete LTC ARF and its attachments, the subacute Facility has not provided the additional requested documents, the subacute Facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. CalOptima Health will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the subacute Facility and mailed to the Member. After a total of twenty-eight (28) calendar days, CalOptima Health will make a decision based on the documentation provided.

J. For Medical Necessity determinations only, if CalOptima Health's LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima Health LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Health Medical Director, or authorized physician designee, for review and determination.

    1. If CalOptima Health's Medical Director, or physician designee, approves the LTC ARF, the CalOptima Health LTSS Department shall send an approval letter with the copy of the approved LTC ARF to the Facility.

3. If CalOptima Health's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima Health LTSS Department shall notify the Facility and the Member, or the Member's Authorized Representative in accordance with CalOptima Health Policies GG.1814: Appeals Process for Long-Term Care Facility and GG.1508: Authorization and Processing of Referrals.

K. CalOptima Health LTSS shall provide Members and Providers with a written Integrated Denial Notice, or Notice of Action, as appropriate, for any decision to deny or modify a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

L. CalOptima Health may dismiss an authorization request for a OneCare Member, either entirely or as to any stated issue, under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an authorization under Title 42, Federal Code of Regulations, § 422.566(c).

2. CalOptima Health determines the party failed to make out a valid request for an authorization.

3. A Member or the Member's Authorized Representative files a request for an authorization but the Member dies while the request is pending, and both of the following apply:

a. The Member's surviving spouse or estate has no remaining financial interest in the case; and

b. No other individual or entity with a financial interest in the case wishes to pursue the organization determination.

4. A party filing the authorization request submits a timely request for withdrawal of their request for an organization determination.

M. CalOptima Health shall mail or otherwise transmit a written notice of the dismissal of the authorization request to the parties. The notice must state all of the following:

1. The reason for the dismissal;

2. The right to request that CalOptima Health vacate the dismissal action; and

3. The right to request reconsideration of the dismissal.

N. A Subacute Facility shall be responsible for:

1. Performing an eligibility verification each month for a CalOptima Health Member who is residing in the Subacute Facility;

2. Performing SOC clearance transactions when a CalOptima Health Member with an unmet SOC is admitted or SOC exceeds the total charges of the contracted rate for a given month's stay;

3. Billing CalOptima Health's Member for the entire SOC if CalOptima Health Member has not spent any of the SOC in the month's stay; and

4. Maintaining the physician's prescriptions for SOC expenditures in CalOptima Health's Member's medical record.

O. Transitional Care Services (TCS)

1. The CalOptima Health LTSS Department shall provide Transitional Care Services (TCS) for Long Term Care (LTC) Members transferring from one setting or level of care to another, in accordance with CalOptima Health Policies GG.1357: Population Health Management Transitional Care Services (TCS)and GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care.

2. CalOptima Health shall ensure care managers are notified when Members are admitted and discharged from LTC or transferred between facilities.

3. CalOptima Health LTSS Department shall identify a care manager as a single point of contact for ensuring completion of all transitional care management services, including follow-up after discharge from LTC.

4. The assigned care manager shall ensure Member transitions to and from LTC are timely and do not delay or interrupt any Medically Necessary services of care, and that all required transitional care activities are completed.

5. Upon discharge from LTC, LTSS staff shall follow-up with Member and provide referrals to other resources as needed, including, but not limited to: Case Management, Enhanced Care Management (ECM), and home and community supports.

P. Discharge Planning:

1. CalOptima Health or a Health Network shall work with the subacute Facility to ensure the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

   a. Documentation of pre-admission, or baseline, status;

   b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification, and integration of community based LTSS programs;

   c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and

   d. Provision of information for making follow-up appointments.

2. A Subacute Facility may modify its care or discharge a Member if the Subacute Facility determines that the following specified circumstances are present:

   a. The Subacute Facility is no longer capable of meeting the Member's health needs; or

b. The Member's condition has improved sufficiently so that the Member no longer needs Subacute Facility services; or

c. The Member poses a risk to the health, or safety, of individuals in the Subacute Facility.

3. CalOptima Health or a Health Network shall be responsible to work with the subacute Facility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the Subacute Facility, that meets the Member's medical and social needs.

4. Upon notification by the Facility of the Member's discharge, the CalOptima Health LTSS Department shall close the active LTC ARF effective the day of discharge. The Facility shall notify CalOptima Health within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to CalOptima Health LTSS Department and submit a completed Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC 171 form) to the appropriate agency.

IV. ATTACHMENT(S)

A. CalOptima Health Long-Term Care (LTC) Authorization Request Form (ARF)
B. Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program (DHCS 6200-A)
C. Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program (DHCS 6200)
D. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Long-Term Care Provider Resource Manual
C. CalOptima Health Policy GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center.
D. CalOptima Health Policy EE.1135: Long-Term Care Facility Contracting
E. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
F. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
G. CalOptima Health Policy GG.1504: Dental Services
H. CalOptima Health Policy GG:1505: Transportation: Emergency, Non-Emergency, and Non-Medical
I. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Health Policy GG.1510: Member Appeal Process
K. CalOptima Health Policy GG.1600: Access and Availability Standards
L. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
M. CalOptima Health Policy GG.1810: Bed Hold, Long Term Care
N. CalOptima Health Policy GG.1811: Leave of Absence, Long Term Care
O. CalOptima Health Policy GG.1814: Appeals Process for Long-Term Care Facility
P. CalOptima Health Policy GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care
Q. CalOptima Health Policy GG.1900: Behavioral Health Services

R. CalOptima Health Policy MA.7020: Behavioral Health Services
S. CalOptima Health Utilization Management Program
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements , Notice and Your Rights
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing Facility Long Term Care Benefit Standardization and Transition of Members to Managed Care.
V. Department of Health Care Services (DHCS) Dual Plan Letter (DPL)16-003: Discharge Planning for Cal MediConnect
W. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
X. Medi-Cal Long-Term Care Provider Manual: Subacute Care Programs
Y. Title 22, California Code of Regulations (CCR), §§ 51003(e), 51118, 51120, 51120.5, 51121, 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51334, 51335, 51335.5 and 51335.6
Z. Title 42, Federal Code of Regulations, § 422.566(c), and 422.568
AA. Welfare and Institution Code, §§ 14103.6 and 14186.1(b) & (c)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/26/2016	Department of Health Care Services	Approved as Submitted
07/15/2022	Department of Health Care Services	File and Use
07/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/02/2022	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/15/1998	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	02/01/2007	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	07/01/2015	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	09/01/2015	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2017	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	06/02/2022	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare
Revised	05/01/2023	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare
Revised	11/01/2023	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare
Revised	09/01/2024	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
21-Day List	A CalOptima Health Form. Long-Term Care Facilities designated for onsite authorization reviews will present all CalOptima Health Member requiring an LTC authorization monthly via the 21-Day List.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by a Member's Authorized Representative.
Facility	Long-Term Care (LTC) Facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF).
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in CalOptima Health's OneCare program, consistent with applicable regulatory and contract requirements.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare (Duals): Means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary of a CalOptima Health program.

Term	Definition
Non-Covered Medical Services	Medical services rendered by a non-Medi-Cal provider; or Medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima Health will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima Health because the service is not considered Medically Necessary.
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in the CalOptima Health Medi-Cal program, consistent with applicable regulatory and contract requirements.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Subacute Facility-Adult	A health Facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the CDPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health Facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing Facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.
Transitional Care Services (TCS)	Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).