DEPARTMENT OF HEALTH CARE SERVICES
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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*ADULT SUBACUTE PROGRAM*

To expedite your request for authorization/reauthorization of SUBACUTE CARE SERVICES, it is **essential** that you complete the information below. Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4. Diagnosis			
5. Medi-Cal number	6. Current level of care	Date of admission	
7. Name of current provider of above level of care			
Address (number, street)	City	State	ZIP Code
8. Family name		Telephone ( )	
Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse; **and**, ... ❒ ❒
please summarize care requirements each shift: _____

b. **One** of the following (1), (2), (3):

(1) Patient has a tracheostomy and requires mechanical ventilation at least 50 percent of the day. ..... ❒ ❒

(2) Patient has a tracheostomy and requires suctioning and room air mist or oxygen **and** one of the treatment procedures listed below (check all that apply). ❒ ❒

- ❒ (a) Total Parenteral Nutrition (TPN)
- ❒ (b) Inpatient physical, occupational, and/or speech therapy at least two hours per day, five days per week.
- ❒ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____
- ❒ (d) Inhalation/respiratory therapy treatments at least 4 times per 24-hour period (not self administered by resident).
- ❒ (e) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
  Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____
- ❒ (f) Wound debridement, packing, and medicated irrigation with/without whirlpool therapy.
  Please explain: _____

(3) Administration of any three of the treatment procedures in b (2) (a) through (f) above. Please check all that apply. ❒ ❒

c. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

d. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

e. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

10. Authorized signature	11. Date

This information is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review or use including disclosure is prohibited.
If you are not the intended recipient of this information, please contact the sender and destroy all copies of the documentation.

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to the local Medi-Cal field office when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the local Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, federal regulations require that the provider continue to complete the MDS and place in the resident's charts. To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification Number:** Please provide Medi-Cal Identification Number

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** per Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

a–b. (4): Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

c. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

d. **Reauthorizations:** Complete this only if this is a ***reauthorization*** for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

e. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.