Subacute Care Programs: Level of Care for Adults and Children

Page Updated: January 2024

This section describes the level of care policy for adult and pediatric subacute care.

TAR Requirement

A *Treatment Authorization Request* (TAR) is required for each admission to a subacute care unit for adults or children. A TAR may be approved for a maximum period of six months. Subsequent reauthorizations may be approved for up to six months.

These restrictions apply to supplemental rehabilitation therapy and ventilator weaning services only.

A completed *Information for Authorization/Reauthorization of Subacute Care Services – Pediatric Subacute Program* (DHCS form 6200) or *Information for Authorization/Reauthorization of Subacute Care Services – Adult Subacute Program* (DHCS form 6200A) must accompany each TAR as justification that the patient requires a subacute level of care. For subacute patients only, the Minimum Data Set (MDS) is no longer required to be submitted with the TAR.

‹‹The forms are only available on the Medi-Cal Providers website on the Forms web page.››

Samples of these forms at the end of this section are for reference only.

All TARs must be sent with their attachments to the TAR Processing Center. Please see the *TAR Field Office Addresses* in this manual for the correct mailing address.

Note: A completed DHCS form 6170 (PASRR) must also be submitted with any TAR requesting subacute level of care.

Drugs

With the exception of items listed in *California Code of Regulations* (CCR), Title 22, Section 51511(b), drugs are not included in subacute per diem rates and may be billed separately by the Pharmacy provider.

Enteral nutritional formulas are included in the subacute per diem rate.

Excluded Items

Other medically necessary covered services, supplies or equipment not listed in the "Per Diem Rate" in the subacute care for adult and pediatric sections, and not included in the subacute per diem rate, may be approved for billing outside the per diem rate subject to the professional judgment of the Medi-Cal consultant.

Billing Procedures

Use the following procedures to bill subacute care:

- ‹‹Subacute care providers bill subacute services on the *UB-04* claim form.››
- To request authorization for subacute services, providers submit *Long Term Care Treatment Authorization Requests* (20-1) and state in *Section C* that the level of care is subacute.
- Physicians bill for subacute services on the *CMS-1500* by specifying the appropriate Place of Service, modifier U2, and billing codes listed in the *Subacute Care Programs: Billing Codes* section in the appropriate Part 2 manual.

Pharmacy Providers

Pharmacy providers who conduct services billed on non-pharmacy claims, should continue to refer to instructions from Medi-Cal when submitting claims on non-pharmacy claim forms. When it comes to billing for subacute care:

- Blood derivatives will be billed on the *CMS-1500* by specifying the appropriate Place of Service and using modifier U2.
- Durable Medical Equipment providers should bill medical supplies and equipment for subacute patients on the *CMS-1500* by specifying the appropriate Place of Service and using modifier U2.

Long Term Care Providers

Subacute care rates are listed in the *Rates: Facility Per Diem* section of the appropriate Part 2 manual.

‹‹Revenue code, value code and value code amount combinations for Long Term Care (LTC) billing are listed in the *Revenue and Value Codes for Long Term Care* section of the appropriate Part 2 manual.››

Policies and Reimbursement

The following policies apply to subacute care:

- ‹‹When a patient no longer requires subacute care, providers must bill that patient's care on the *UB-04* claim form using the standard provider number and the appropriate revenue code, value code and value code amount combination. Reimbursement is at each facility's existing DP/NF or free-standing NF rate.››
- The program allows bed hold days and leave of absence (LOA) days for a subacute care recipient during acute hospitalization, subject to current reimbursement policy.
- Podiatric reimbursement is limited to CPT® codes 99221 thru 99223, 99231 thru 99233, 99238, 99239, 99242 thru 99245, and 99252 thru 99255.
- CPT codes 94010 thru 94799 (pulmonary tests) can be billed separately by the physician.
- Billing and reimbursement for Medicare/Medi-Cal crossover services remain the same.
- Providers may not bill the County Medical Services Program (CMSP) for subacute services. A CMSP recipient requiring subacute care is issued a Medi-Cal card with aid code 53. The provider may then bill Medi-Cal for LTC for that patient.

  Note: A subacute care patient with aid code 53 who requires inpatient acute care services must obtain an aid code category change to add aid code 8F before the provider can bill CMSP for inpatient services.
- Surgical Codes – There is no Place of Service restriction for subacute programs. All surgical procedure codes that are payable in an acute hospital, nursing facility or outpatient facility are reimbursable for a subacute contract facility when performed by a physician at the facility.

Subacute Care Unit: Program Enrollment and Inquiries

To request an application or information regarding the Adult or Pediatric Subacute Care Programs, providers should call or write:

Department of Health Care Services

Safety Net Financing Division

Subacute Care Unit

MS 4504

1501 Capitol Avenue, Suite 71.2101

P.O. Box 99736

Sacramento, CA 95899-7436

(916) 552-9113

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.