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

☐ Initial ☐ Reauthorization ☐ Transfer

Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4.Primary Diagnosis (and any secondary diagnoses pertinent to the level of care)			
5. Medi-Cal Identification 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 PEDIATRIC SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse and is under 21 years of age; and ☐ ☐

b. One of the following (1), (2), (3), (4), or (5):

(1) Patient has a tracheostomy and requires mechanical ventilation at least six hours per day. ..... ☐ ☐

(2) Patient has a tracheostomy and requires suctioning at least every six hours and room air mist or oxygen; **and** one of the treatment procedures listed below (check all that apply). ☐ ☐

❒ (a) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____

_____

❒ (b) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.

❒ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____

❒ (d) Other daily medical technologies required continuously which, in the opinion of the attending physician and the Medi-Cal consultant, require the services of a professional nurse.
Please summarize care requirements each shift: _____

_____

❒ (e) Dependence on biphasic positive airway pressure at least six hours a day, including assessment or intervention every three hours, where the patient lacks either the cognitive or physical ability to protect their airway.

(3) Dependence on total parenteral nutrition (TPN) or other intravenous nutritional support; **and** one of the treatment procedures listed above in (2) (a) through (e); including (f) below (check all that apply). ☐ ☐

❒ (f) Intermittent suctioning (nontracheostomy) at least every eight hours, **and** room air mist or oxygen.

(4) Dependence on skilled nursing care in the administration of any three of the treatment procedures in a (2) (a) through (e), including (3) (f) listed above. Please check all that apply. ☐ ☐

(5) Dependence on biphasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures specified in a (2) (a) through (e), including (3) (f) above. ☐ ☐

b. 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.

_____

c. 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.

d. 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

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—PEDIATRIC SUBACUTE PROGRAM

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 Medi-Cal TAR Processing Center 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 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.

Please indicate in one of the boxes under the title if this is an initial TAR for subacute care, a reauthorization for subacute care, or the patient is being transferred from another facility or home.

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:** Welfare & Institutions Code 14132.25; Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

   a. (1) – (5) : Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

   b. **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).

   c. **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).

   d. **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.