METHOD OF INDICATING CHANGES

This Accessible PDF version of the approved regulation text includes the phrase [begin underline] at the beginning of each addition, [end underline] at the end of each addition, [begin strikeout] at the beginning of each deletion, and [end strikeout] at the end of each deletion.

A standard PDF version of this approved regulation text is also available on the Department's Office of Regulations Internet site.

(1) Amend Section 51003 as follows:

Section 51003. Treatment Authorization Requests (TARs).

(a) “Prior authorization,” or “authorization” means authorization granted by a designated Medi-Cal consultant or by a Primary Care Case Management (PCCM) plan and is obtained through submission and approval of a TAR. The responsibilities of the Medi-Cal consultant shall not be delegated, except to the extent provided under Sections 51013 and 51014. Authorization may be granted by a PCCM plan only for beneficiaries enrolled in that PCCM plan and the responsibilities of the PCCM plan shall not be delegated except as provided under Section 51003.7.

(b) A TAR received by the Department from a Fee-For-Service Medi-Cal provider shall be reviewed for medical necessity only.

(c) “Reauthorization” means authorization of a new TAR for continuation of previously authorized Medi-Cal services.

(1) “Request for Non-Acute Continuing Services,” as used in Section 51014.1(e), means a new TAR for continuation of previously approved services received by the Department from Fee-For-Service Medi-Cal providers in the following categories:

(A) Long-Term Care, specifically Skilled Nursing Facility, Intermediate Care Facility and Subacute levels of care.

(B) General Inpatient Hospice Care.

(C) Home and Community-Based Waiver Services, including all related services.

(D) Early Periodic Screening Diagnosis and Treatment (EPSDT) Supplemental Home Nursing and Related Services.

(E) All other non-acute services under the Medi-Cal program when the treating physician (i.e., the physician, podiatrist, or dentist who is treating the beneficiary and certifying that the services must be continued) substantiates on or with the request in writing that the same level or frequency of services should be continued because the treatment goal approved on the original TAR has not been achieved, without regard to the length of time the service has been provided. To meet the requirement to substantiate the need for continuing care, justification of medical necessity shall be submitted pursuant to subsection (d).

(2) "Request by a provider for Acute Continuing Services," as used in Section 51014.1(f), means a Request for Extension of Stay in Hospital, form 18-1 (8/93) used for approval of acute care services in hospitals, including submission of requests to on-site Medi-Cal reviewers or to the local Medi-Cal Field Office. This request shall be submitted when the treating physician (i.e., the physician, dentist or podiatrist certifying the need for acute care pursuant to Section 51327(a)(3)(A)) has determined that the beneficiary cannot safely be discharged because acute care services continue to be medically necessary, for one of the following reasons:

(A) Further acute care is needed for the purpose of treating the condition or conditions for which acute care was originally approved for an acute admission requiring authorization.

(B) Complications directly related to the diagnosis for which acute care was originally approved have arisen and necessitate further acute care.

(C) Further acute care is needed for an illness contracted during the course of an approved acute admission if the illness most likely occurred because the beneficiary was hospitalized.

(d) In addition to the information specified in Section 51456, a provider submitting a TAR shall explain why the services are medically necessary or submit supporting documentation indicating medical necessity.

(e) Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi-Cal Authorization," published by the Department in January 1982, last revised [begin strikeout] ~~April 11, 2011~~ [end strikeout] [begin underline] May 1, 2013 [end underline], and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi-Cal consultants or PCCM plans in their decisions on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified by the Medi-Cal consultant or PCCM plan up to a maximum of 180 days, unless otherwise specified in this chapter. The Medi-Cal consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years.

(f) Authorization may be granted only for the lowest cost item or service covered by the Medi-Cal program that meets the beneficiary's medical needs.

(g) A provider may appeal the decision of a Medi-Cal consultant on a TAR pursuant to Section 51003.1. A provider appealing the decision of a PCCM plan on a TAR shall file the appeal in accordance with Section 56262.

(h) Rural Health Clinics and Federally Qualified Health Centers are not subject to TAR requirements.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code; and Sections 20 and 1267.7, Health and Safety Code. Reference: Sections 14053, 14064, 14081, 14087, 14088, 14088.16, 14088.2, 14103.6, 14105.12, 14132, 14132.22, 14132.25, [begin strikeout] ~~14132.42, 14132.8,~~ [end strikeout] 14133, 14133.05, 14133.1, 14133.25 and 14133.3, Welfare and Institutions Code; *Jeneski v. Meyers* (1984) 163 Cal. App. 3d 18, 209 Cal. Rptr. 178; *Duran v. Belshé*, San Diego County Superior Court Case No. 674204, (1995); and *Fresno Community Hospital and Medical Center v. State of California, et al.*, Fresno County, Superior Court Case No. 555694-9, (1996).