



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

OCT 13 2011

Toby Douglas, Director  
California Department of Health Care Services  
1501 Capitol Avenue, 6th Floor  
MS: 0000  
Sacramento, CA 95814

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 11-019, which authorizes all certified nurse practitioners (CNP) to bill Medicaid independently and, in those cases, the Department of Healthcare Services will pay the CNP independently. The SPA is effective July 1, 2011.

Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- **Limitations on Attachment 3.1-A, pg 12a**
- **Limitations on Attachment 3.1-A, pg 12b**
- **Limitations on Attachment 3.1-B, pg 12a**
- **Limitations on Attachment 3.1-B, pg 12b**
- **Attachment 3.1-A, pg 8a**
- **Attachment 3.1-B, pg 7**
- **Limitations on Attachment 3.1-A, Pg 24a**
- **Limitations on Attachment 3.1-B, pg 24**

If you have any questions, please contact Carolyn Kenline at (415) 744-3591 or at [carolyn.kenline@cms.hhs.gov](mailto:carolyn.kenline@cms.hhs.gov).

Sincerely,

Original Signed

Gloria Nagle, Ph.D., M.P.A.  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosure

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**11-019**

2. STATE  
California

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
July 1, 2011

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 U.S.C. 1396d(a)(6), 42 CFR Sections 440.60 and 441.22

7. FEDERAL BUDGET IMPACT:

- a. FFY ~~2011-12~~ 2012 \$ None
- b. FFY ~~2012-13~~ 2013 \$ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, page 8a  
Attachment 3.1-B, page 7  
Limitations on Attachment 3.1-A, page 24a, page 12a, and page 12b  
Limitations on Attachment 3.1-B, page 24, page 12a, and page 12b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 3.1-A, page 8a, ~~FN 93-015~~  
Attachment 3.1-B, page 7, ~~FN 95-006~~  
Limitations on Attachment 3.1-B, page 24, ~~FN 93-015~~  
~~Limitations on Attachment 3.1-A, page 12a~~  
~~Limitations on Attachment 3.1-B, page 12a~~

10. SUBJECT OF AMENDMENT:

Expand coverage of nurse practitioner services to authorize all certified nurse practitioners to bill Medi-Cal independently pursuant to State legislation.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:  
The Governor's Office does not wish to review the State Plan Amendment.

Original Signed

**Toby Douglas**

14. TITLE:

**Director**

15. DATE SUBMITTED: **JUL 18 2011**

6. RETURN TO:

Department of Health Care Services  
Attn: State Plan Coordinator  
1501 Capitol Avenue, Suite 71.3.26  
P.O. Box 997417  
Sacramento, CA 95899-7417

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: July 18, 2011

18. DATE APPROVED: **OCT 13 2011**

PLAN APPROVED - ONE

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011

Original Signed

21. TYPED NAME: **Gloria Nagle**

22. TITLE: **Associate Regional Administrator**

23. REMARKS: Pen and ink changes to boxes 7, 8, and 9 were approved on September 30th.

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4 Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

\* Prior authorization is not required for emergency services.

\*\* Coverage is limited to medically necessary services.

TN Number: 11-019

Supersedes

TN Number: None

Approval Date: OCT 13 2011

Effective date: July 1, 2011

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>7. Home Health Services</p> <p>Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.</p>	<p>Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services:</p> <ol style="list-style-type: none"> <li>1. Skilled nursing services as provided by a nurse licensed by the state</li> <li>2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110</li> <li>4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>5. Home health aide services provided by a Home Health Agency</li> </ol> <p>Medical supplies, equipment, and appliances suitable for use in the home.</p>	<p>One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.</p>
<p>7a. Home health nursing 7b. and aide services</p>	<p>Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.</p>	<p>One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.</p>

\*Prior authorization is not required for emergency services

\*\*Coverage is limited medically necessary services.

TN No. 11-019  
Supersedes  
TN No. 09-001

Approval Date: OCT 13 2011

Effective Date: July 1, 2011

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-B

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4 Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

\* Prior authorization is not required for emergency services.

\*\* Coverage is limited to medically necessary services.

TN Number: 11-019

Supersedes

TN Number: None

Approval Date: OCT 13 2011

Effective date: July 1, 2011

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-B

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>7. Home Health Services</p> <p>Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.</p>	<p>Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services:</p> <ol style="list-style-type: none"> <li>1. Skilled nursing services as provided by a nurse licensed by the state</li> <li>2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110</li> <li>4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>5. Home health aide services provided by a Home Health Agency</li> </ol> <p>Medical supplies, equipment, and appliances suitable for use in the home.</p>	
<p>7a. Home health nursing 7b. and aide services</p>	<p>Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.</p>	<p>One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.</p>

\*Prior authorization is not required for emergency services

\*\*Coverage is limited medically necessary services.

TN No. 11-019  
Supersedes  
TN No. 09-001

Approval Date: OCT 13 2011

Effective Date: July 1, 2011

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
TO THE MEDICALLY NEED GROUP(S): \_\_\_\_\_

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## 19. Case management services and Tuberculosis related activities

- a. Case management services as defined in, and to the group specified in, Supplemental 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1h to ATTACHMENT 3.1-A for County-Funded Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

  X   Provided:              X   With limitations\*                 Not provided

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

  X   Provided:              X   With Limitations\*                 Not provided

## 20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60<sup>th</sup> day falls.

  X   Provided: +                 Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

  X   Provided: +                 Additional coverage ++                 Not provided

## 21. Certified pediatric or family nurse practitioners' services.

  X   Provided:                 No Limitation              X   With limitations\*  
     No provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services of services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\* Description provided on attachment.

TN No. 11-019

Supersedes

TN No. 95-006Approval Date OCT 13 2011Effective Date July 1, 2011

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B  
Page 24

	TYPE OF SERVICES	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Extended services for pregnant women.	Preventive Services provided in the home, by Comprehensive Perinatal Services Providers, which are clinics and hospital outpatient departments, as medically necessary for pregnancy-related conditions only. Services are covered throughout pregnancy and through the end of the month in which the 60 <sup>th</sup> day period following termination of pregnancy ends.	Prior authorization is required when services are provided in excess of the basic allowances. Basic allowances are described in Title 22, Sections 51348 and 51504.
21	Certified pediatric or family nurse practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.166.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

\* Prior authorization is not required for emergency services.

\*\* Coverage is limited to medically necessary services.

TN No. 11-019  
Supersedes  
TN No. 93-015

Approval Date: OCT 13 2011

Effective Date: July 1, 2011

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in Accordance with section 1920 of the Act).

X  Provided:   No Limitations  X  With limitations\*  
Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

Provided:   No Limitations   With limitations\*  
 X  Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided:   No Limitations  X  With limitations\*

\* Description provided on attachment.

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TN No. 11-019

Supersedes

TN No. 93-015

Approval Date OCT 13 2011 Effective Date July 1, 2011

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A  
Page 24a

TYPE OF SERVICES	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
23 Certified pediatric or family nurse practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.166.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP, prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

\* Prior authorization is not required for emergency services.

\*\* Coverage is limited to medically necessary services.

TN No. 11-019  
Supersedes  
TN No. none

Approval Date: OCT 13 2011

Effective Date: July 1, 2011