TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental disease are covered only for persons under 21 years of age or for persons 65 years of age and over. It includes Administrative Day Level 1 and Administrative Day Level 2 Services. Administrative Day Level 1 and Level 2 Services are inpatient hospital services provided to a beneficiary who has been admitted to the hospital for general acute care inpatient services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for general acute care inpatient services due to a temporary lack of placement options to a nursing home, subacute, or post acute care that is not yet available that meets the needs of the beneficiary. The beneficiary must meet a nursing home level A or nursing home level B level of care to be eligible for Administrative Day Level 1 Services and subacute care to be	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindicated.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services (Continued)	eligible for Administrative Day Level 2 Services.	
	Services in the psychiatric unit of a general hospital are covered for all age groups.	Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization by the Medi-Cal Consultant.
	It includes Psychiatric Inpatient Hospital Services.	Beneficiaries must meet medical necessity criteria.
	Psychiatric Inpatient Hospital Services are both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.	
	Acute psychiatric inpatient hospital services are those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.	
	Administrative day services are psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the	

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services (Continued)	hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary. Psychiatric Inpatient Hospital Services are provided in accordance with 1902(a)(20)(A),(B), (C) and 1902(a)(21) of the Social Security Act (the Act) for beneficiaries ages 65 and over and with 1905(a)(16) and (h) of the Act for beneficiaries under age 21.	

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services)	TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital. Medical necessity includes, but is not limited to, one or more of the following: 1. Intravenous therapy, including but not limited to: • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration Note: The clinical record must document failure of other preventive measures, failure or inappropriateness of non-intravenous medications or the patient's inadequate response to oral hydration.	Prior authorization is required for TC level of care. The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care. A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management. The attending physician must perform the initial medical visit within 24 hours of the patient's admission to TC level of care. For patients admitted from acute care hospitals, if the physician assuming the responsibility for treatment management in TC was also the attending physician in the acute care hospital, the initial physician visit must occur within 72 hours.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

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** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	• Has potential to make significant functional gain in a reasonable period of time or has a caregiver available to participate in short-term training that will enable the patient to return safely to a residential environment with the caregiver's assistance. B. The transitional medical patient, who has a need for rehabilitation therapy as ordered by the physician.	Not covered by TC: • Obstetrical patients • Patients receiving anti-cancer intravenous cytotoxic drugs • Patients with highly complex multiple rehabilitation needs that include intensive social and/or psychological interventions in order to adjust to their disability or in order to be discharged safely to a residential setting • Patients with a primary psychiatric diagnosis, or any disorder resulting in behaviors that require an intensive, highly structured behavior management and/or cognitive retraining program

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** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3. Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing.	
	4. Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours.	
	5. Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a Hospital outpatient department services and community hospital outpatient clinic.	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational Therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physician's services 19. Family planning 20. Respiratory care 21. Ambulatory surgery 22. Dental	Refer to appropriate service section for prior authorization requirements

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a Hospital outpatient department services and community hospital outpatient clinic.		All services, including physician's services, are subject to the same requirements as when provided in a non-facility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program of the SD/MC system.
2b Rural Health Clinic services and other ambulatory services covered under the state plan.	The following Rural Health Clinic (RHC) services are covered under this state plan: 1. Physician services For RHC purposes, physicians are defined as follows: a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license b. A doctor of podiatry authorized to practice podiatric medicine by the State who is acting within the scope of his/her license c. A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license d. A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license	Rural health clinics do not require Treatment Authorization Request (TAR) before rendering services; however, RHCs must provide documentation in the medical record that the service was medically necessary.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	e. A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license 2. Physician Assistant (PA) who is authorized to practice PA services by the State and who is acting within the scope of his/her license 3. Nurse Practitioner (NP) who is authorized to practice NP services by the State and who is acting within the scope of his/her license. 4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license 6. Comprehensive Perinatal Services Program (CPSP) practitioner services 7. Licensed clinical social worker services who is authorized to practice social work services by the State and who is acting within the scope of his/her license 8. Clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license	

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**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan.	Acupuncture, audiology, chiropractic, dental, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: 1. Pregnant women, if the optional benefit is part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program Psychology services are covered in RHCs for all Medi-Cal beneficiaries. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, psychology, and speech therapy. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services. Federally required adult dental services are covered in RHCs for all Medi-Cal beneficiaries.	
	Rural Health Center home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

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STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan.	The following FQHC services are covered under this state plan: 1. Physician services For FQHC purposes, physicians are defined as follows: a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license. b. A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license. c. A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license. d. A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license. e. A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license. 2. Physician Assistant (PA) who is authorized to practice PA services by the State and who is acting within the scope of his/her license. 3. Nurse Practitioner (NP) who is authorized to practice NP services by the State and who is acting within the scope of his/her license.	FQHC do not require Treatment Authorization Request (TAR) before rendering services; however, FQHC must provide documentation in the medical record that the service was medically necessary.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license 6. Comprehensive Perinatal Services Program (CPSP) practitioner services 7. Licensed clinical social worker services who is authorized to practice social work services by the State and who is acting within the scope of his/her license 8. Clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license Acupuncture, audiology, chiropractic, dental, podiatry, speech therapy, are covered optional benefits only for the following beneficiaries: 1. Pregnant women if the optional benefit is part of their pregnancy-related services or for services to treat a condition that might complicate the pregnancy.	

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program. Psychology services are covered in FQHCs for all Medi-Cal beneficiaries. The following services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, podiatry, psychology, and speech therapy. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services. Federally required adult dental services are covered in FQHCs for all Medi-Cal beneficiaries. FQHC home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

S PLAN CHART

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3	Laboratory, radiological, and radioisotope services	As required on order of a licensed practitioner except laboratory services provided in renal dialysis centers and community hemodialysis units are payable only when billed by the center or unit.	Prior authorization is required for nonemergency portable X-ray services unless perfor in a skilled nursing facility (SNF) or intermediate care facility (ICF).
4a	Skilled nursing facility	Covered when patient has need for daily skilled nursing and/or daily special rehabilitation services which, as a practical matter, can only be provided on an inpatient basis.	Prior authorization is required.
			Attending physicians must recertify a patie level of care and plan every 60 days.
		The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	For patients having Medicare as well as Med eligibility (crossover cases), authorizatio required at the time of Medicare denial or before the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.1	Subacute care services (SNF)	This is a more intensive SNF level of care. Covered when patient has need for intensive licensed skilled nursing care. The patient must be visited by a physician at least twice weekly during the first month and a minimum of at least once every week thereafter. Subacute units must provide sufficient licensed nursing staff to provide a minimum daily average of 4.8 actual licensed nursing hours per patient day for nonventilator-dependent patients and 6.2 licensed nursing hours per patient day for ventilator-dependent patients.	Same as 4a above. Initial care may be authorized for up to two months. Prolonged care may be authorized for up to a maximum of four months.

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** Coverage is limited to medically necessary services.

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(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Minimal standards of medical necessity for the subacute level of care include: A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter. B. Twenty-four hour access to services available in a general acute care hospital. C. Special equipment and supplies such as ventilators. D. Twenty-four hour nursing care by a registered nurse or licensed vocational nurse.	

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** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	E. Administration of three or more of the following treatment procedures: 1. Traction and pin care for fractures (this does not include Bucks Traction). 2. Total parenternal nutrition. 3. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week. 4. Tube feeding (NG or gastrostomy). 5. Tracheostomy care with suctioning. 6. Oxygen therapy and/or inhalation therapy treatments during every shift and a minimum of four times per 24-hour period.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	7. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via Heparin lock.	
	8. Medically necessary isolation precautions as recommended by the Centers for Disease Control. (Infection control measures for the care of decubitus ulcers do not apply in this category).	
	9. Debridement, packing, and medicated irrigation with or without whirlpool treatment.	
	10. Continuous mechanical ventilation for at least 50 percent of each day.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.2 Pediatric subacute services (NF)	Pediatric subacute care services are the services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Covered when medical necessity is substantiated as follows: Patient requires any one of the following items in 1-4 below: 1. A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day; 2. Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in B through E below:	Same as 4a above. A Treatment Authorization Request shall be required for each admission to a subacute unit caring for pediatric patients, and may be granted for a period of up to six months and reauthorized for a period of up to six months.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	A. Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;	
	B. Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion;	
	C. Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	D. Dependence on tube feeding, naso-gastric or gastrostomy tube;	
	E. Dependence on other medical technologies required continuously, which in the opinion of the attending physician and the Medi-Cal consultant require the services of a professional nurse.	
	3. Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	4. Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (b)(2)(A) through (E) above; Medical necessity shall be further substantiated by all of the following conditions: 1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the patient's health care needs, and not be any less than the nursing staff ratios specified in Section 51215.8 (g) and (i);	

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** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	2. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary;	
	3. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.	
	Patients shall be visited by their physician at least twice weekly during the first month of stay, and a minimum of once each week thereafter.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.3 Transitional Inpatient Care (TC) (Nursing Facility)	TC is covered when provided in qualified SNFs that have a TC contract with the Department of Health Services. See 1.1.	Prior authorization is required for TC level of care. The physician must conduct a comprehensive medical assessment and determine the patient has been clinically stable for the 24 hours preceding admission to the TC level of care in a SNF. Preadmission screening must be conducted for all patients admitted to TC level of care in a SNF by an appropriate facility clinician. Bed hold is covered for nursing facility level A or level B patients who are authorized for TC level of care. See 1.1.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b Early and periodic screening, diagnostic, and treatment (EPSDT) services	Covered for Medi-Cal eligibles under 21 years of age.	Prior authorization is not required.
	Includes rehabilitative mental health services: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day treatment intensive, day rehabilitation offered in local and mental health clinics or in the community, as described in Attachment 3.1-A, Item 13.	Medical necessity is the only limitation.
Services provided by Local Education Agency (LEA) providers	Includes Local Education Agency (LEA) Medi-Cal Billing Option Program services (LEA services). LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California Campus.	Service Limitations Services provided by LEA providers are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for services provided by LEA providers beyond 24 services per 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student; • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management).

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	LEA services are defined as: Non-IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.	LEA services are covered when provided to, or directed exclusively toward the treatment of, a Medicaid eligible student under 21 years of age. Provider Qualifications Services must be performed by providers who meet the applicable qualification requirements as described in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed speech-language pathologists (formerly credentialed language, speech and hearing specialists), credentialed audiologists (formerly credentialed language, speech and hearing specialists), licensed physical therapists, registered occupational therapists, and registered dieticians. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110.

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**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.	In addition, the following limitations apply: • Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students. • Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students. • Credentialed audiologists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of a licensed audiologist only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students.

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STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	<u>Treatment Services</u> • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); • Medical transportation (as covered in Subsection 24(a).	• Credentialed speech-language pathologists who have a preliminary or professional clear services credential in speech-language pathology may provide assessments and treatment services related to speech, voice, language, or swallowing disorders, for which a student has been referred by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students. Credentialed speech-language pathologists who do not have a preliminary or professional clear services credential in speech-language pathology may provide services under the direction of a licensed speech-language pathologist or a credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110. • Credentialed pupil service workers may provide psychosocial assessments only; • Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only; • School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b EPSDT (cont.) Services provided by LEA providers (cont.)		• The definition of "under the direction of" a licensed audiologist, licensed speech-language pathologist or credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology is that the practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed practitioners that he or she agrees to direct. The practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. Services provided by LEA providers may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

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STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b EPSDT (cont.) Infant Development Program Services (IDP)	The Infant Development Program (IDP) services offer a variety of medically necessary services identified in an Individualized Family Service Plan (IFSP). The Department of Developmental Services contracts with Regional Centers (RC) statewide to provide and coordinate services for infants with, and at risk for, developmental disabilities. Individuals are not limited to RC providers, and may receive state plan services through their health plan or fee for service providers. IDP services will not be provided to an infant at the same time as another service that is the same in nature and scope.	IFSP Assessments: Infants and toddlers eligible for IDP services will have an IFSP developed by a RC multidisciplinary team, which includes a physician or licensed practitioner who authorizes specific medically necessary services, including frequency and duration, within the scope of their practice under state law. IFSPs are reviewed and updated at least every six months. Provider Qualifications: Providers must meet all applicable license, credential, registration, certificate, permit, or academic degree requirements to provide the service under state law. Unlicensed providers may also provide services under the direct supervision of a licensed member of the IFSP multidisciplinary team, as defined in this section, pursuant to their scope of practice under state law. Unlicensed providers may have a bachelor's degree in education, psychology, child development or related field; or an AA degree in child development or related field.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b EPSDT (cont.) IDP (cont.)	Physical therapy services provided in accordance with Item 11a. Occupational therapy services provided in accordance with Item 11b. Audiology services provided in accordance with Item 11c. Speech therapy services provided in accordance with Item 11c.	Services must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.110, licensed and within their scope of practice under state law.
	Vision services provided in accordance with Item 5a.	Services must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.50, licensed and within their scope of practice under state law.
	Psychology services provided in accordance with Item 6 d.1.	Services must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.60, licensed and within their scope of practice under state law.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b EPSDT (cont.) IDP (cont.)	Developmental Therapy is a service that includes activities that increase the parent's/caregiver's recognition and response to the child's verbal and/or non-verbal communication; increase the parent's/caregiver's interpersonal relationship with the child through everyday activities; training and consultation with the parent/caregiver for the direct benefit of the child to demonstrate developmentally appropriate activities for the child's special need to support the acquisition of new skills; and address the achievement of the objectives and outcomes in the child's IFSP. Intervention activities promote development in all of the following areas: gross motor skills; fine motor skills; cognitive development; communication development; social-emotional development; and self-help/adaptive learning. Activities may include, but are not limited to, use of manipulative props and toys, and weights; play and music therapy; role play; responding to the infant/toddler; positive caregiving strategies; and development of routine and ritual. Developmental therapy is provided under the direction of the multidisciplinary IFSP team at the RC, including licensed personnel, to ensure the continuity of the medically necessary services to ameliorate the child's delays and by guiding the therapeutic regimen related to the child's progress.	Developmental therapy may be provided by unlicensed IDP providers, as described on page 9e. Developmental therapy services provided by unlicensed providers are provided in accordance with the preventive benefit (42 CFR 440.130(c)).

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b EPSDT (cont.) IDP (cont.)	Treatments are recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law.	
4c Family planning services and supplies for individuals of child bearing age.	Covered as physician and pharmaceutical services.	Prior authorization is not required, and informed consent must be obtained in compliance with applicable state law for all sterilizations. Sterilization of persons under 21 years of age is not covered.
5a Physician's Services	As medically necessary, subject to limitations; however, experimental services are not covered.	Physician services do not require prior authorization except as noted below:

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)	Outpatient medical procedures such as hyperbaric 0^2 therapy, psoriasis day care, apheresis, cardiac, catherization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.
	Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physican are considered to be physician services for purposes of program coverage.	Prior authorization is required for the following: Injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	Shall include services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist. Routine eye examinations with refraction are provided when medically necessary.	

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPES OF SERVICE	PROGRAM COVERAGE**	AUTHORIZATION AND OTHER REQUIREMENTS*
5a Physician's Services (continued)	Outpatient heroin or other opioid detoxification services are administered or prescribed by a physician, or medical professional under the supervision of a physician.	Outpatient heroin or other opioid detoxification services require prior authorization and are limited to 21 consecutive calendar days of treatment, regardless if treatment is received each day. When medically necessary, additional 21-day treatments are covered after 28 days have elapsed from the completion of a preceding course of treatment. During the 28 day lapse, beneficiaries can receive maintenance treatment. Services are covered for beneficiaries under the age of 21 years when medically necessary. The narcotic drug methadone can only be rendered in state licensed Narcotic Treatment Programs, as required by federal and state law. Other narcotic and non-narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Additional charges may be billed for services medically necessary to diagnose and treat disease(s) which the physician believes are concurrent with, but not part of, outpatient heroin or other opioid detoxification services. Services are covered to the extent that they are permitted by federal law.

*Prior Authorization is not required for emergency services.
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5b. Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C Section 1396(a)(5)(B), are covered.	Pursuant to 42 CFR Section 440.50(b), medical and surgical services of a dentist means medical or surgical services furnished by a physician or a doctor of medicine or dental surgery.	Medical and surgical services furnished by a dentist, as described, administered, through a contract with the Medi-Cal Dental Fiscal Intermedicary (Dental FI). Subject to state supervision, discretion, and oversight, and applicatble federal and state statutes, regulations, and manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatrists' services	Podiatry service is a covered optional benefit only for the following beneficiaries: 1. Pregnant women, if the podiatry services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program.	All services provided in SNFs and ICFs are subject to prior authorization.
	Podiatry services are covered in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries.	
	Outpatient podiatry services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services.	Routine office visits do not require a TAR. A TAR is required for all podiatry services that exceed the two-visit limit, except emergencies.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

Routine nail trimming is not covered.

Inpatient services are covered only on written order of the physician or podiatrist who admits the patient to the hospital, and only when the period of hospital stay is covered by the program

Podiatry services are limited to treatment of disorders of the feet which complicate, or are secondary to, chronic medical diseases or which significantly impair the ability to walk.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6c Chiropractic services	Chiropractic services are covered under this state plan when provided by a chiropractic practitioner licensed by the state. Chiropractic services are limited to manual manipulation of the spine. This is a covered optional benefit under this plan only for the following beneficiaries: 1. Pregnant women, if chiropractic services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program. Oupatient chiropractic services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, occupational therapy, podiatry, psychology, and speech therapy. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services.	TAR is required for a chiropractic service visit that exceeds the two-visit limit.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.1 Psychology	Psychology services are covered as a benefit under this plan when provided by a psychologist, clinical social worker, or marriage and family therapist (MFT) licensed by the state. Registered MFT interns, registered associate clinical social workers (ASWs), and psychological assistants may also provide psychology services under the direct supervision of a licensed mental health professional, that is within their scope of practice in accordance with applicable state laws. Psychology services are covered outpatient settings for all Medi-Cal beneficiaries.	TAR approval is not required for outpatient psychology services.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.2 Nurse anesthetist services	Nurse anesthetists as licensed by the state may administer all types of anesthesia within their scope of licensure.	

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d3 Acupuncture services	Covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Acupuncture services are covered under this state plan only for the following beneficiaries: 1. Pregnant women, if acupuncture services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program. Acupuncture services are available in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries.	
	Outpatient acupuncture services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: audiology, chiropractic, occupational therapy, podiatry, psychology, and speech therapy. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 for psychology services.	TAR is required for an acupuncture service visit that exceeds the two-visit limit.

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	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.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7.	Home Health Services 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.	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: 1. Skilled nursing services as provided by a nurse licensed by the state 2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110. 3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110 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. 5. Home health aide services provided by a Home Health Agency Medical supplies, equipment, and appliances suitable for use in the home.	
7a. 7b.	Home health nursing and aide services	Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.	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.

*Prior authorization is not required for emergency services
**Coverage is limited medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies	As prescribed by a licensed practitioner within the scope of his or her practice.	Prior authorization is required for supplie listed in the Medical Supplies Formulary. Certain items require authorization unless for the conditions specified in the Medical Supplies Formulary.
	Common household items, supplies not primarily medical in nature, and articles of clothing are not covered.	
	Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable.	
	Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	
	Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required.
		Certification that voluntary blood donations cannot be obtained is required from blood ba supplying the blood or facility where transf is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	Covered when prescribed by a licensed physician and reviewed annually. DME commonly used in providing SNF and ICF level of care is not separately billable. Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $25, except that the provision of more than two "H" oxygen tanks in any one month requires prior authorization. Purchase or rental of "By Report" (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3	Hearing aids	Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."	Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."
7c.4	Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a licensed physician within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services

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STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d Physical and occupational therapy, speech therapy and audiology services provided by a home health agency.	See 11. The two-visit limit does not apply to therapies provided in the home health setting.	See 11.
8 Special duty nursing services.	Not covered	
9 Clinic services	Clinic services are covered under this state plan. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include outpatient heroin or other opioid detoxification services. Services shall be furnished at the clinic by or under the direction of a physician or dentist. Acupuncture, audiology, chiropractic, dental, incontinence creams and washes, optometry, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program.	Refer to appropriate service section for prior authorization requirements Narcotic Treatment Programs pursuant to federal and state regulations are the only facilities that may administer methadone for heroin or other opioid detoxification services. Other narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Refer to type of service "5a Physician Services" for prior authorization and other requirements for outpatient heroin or other opioid detoxification services.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
9 Clinic Services (continued)	The following services are subject to a two-services limit in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, podiatry, psychology, and speech therapy. Effective January 1, 2014, psychology services are available to all Medi-Cal beneficiaries and the two-visit limit does not apply. See Item 6d.1 regarding psychology services.	
10 Dental services	Dental benefits for adults are limited to the following medically necessary services: Examination, radiographs/photographic images, prophylaxis, fluoride treatments, amalgam and composite restorations, stainless steel, resin, and resin window crowns, anterior root canal therapy, complete dentures (including immediate dentures once every five years) and complete denture adjustments, repairs and relines. Additional services may be covered when medically necessary for pregnant individuals or individuals under age 21 who are eligible for benefits under the Early and Periodic Screening, Diagnosis, and Treatment Program. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits.	Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). On behalf of the state, the Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization is required in general for crowns (except stainless steel crowns), root canal treatments, treatment of periodontal disease, dentures, implants, some complex oral surgical procedures, and orthodontic treatment. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
	For eligible beneficiaries 21 years of age and older (non-EPSDT), an $1,800 annual benefit limit applies, although this limit can be exceeded based on medical necessity through prior authorization. The following are exceptions to the limit: • Emergency dental services • Services including pregnancy-related services and for other conditions that might complicate the pregnancy. • Dentures • Dental implants and implant-retained prostheses.	

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11a.	Physical Therapy	Physical therapy is covered for the restoration, maintenance and acquisition of skills only when prescribed by a physician, dentist, or podiatrist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Outpatient physical therapy provided in a certified rehabilitation center is covered only when billed by the rehabilitation center. In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	All physical therapy services are subject to prior authorization. Services must be performed by providers who meet the applicable qualification requirements as defined for physical therapy in 42 CFR Section 440.110(a), licensed and within their scope of practice under state law. More than one evaluation visit in a six-month period requires authorization.

*Prior Authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11b. Occupational Therapy	Occupational therapy is covered for the restoration, maintenance and acquisition of skills only when prescribed by a physician, dentist, or podiatrist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity.	Services must be performed by providers who meet the applicable qualification requirements as defined for occupational therapy in 42 CFR Section 440.110(b), licensed and within their scope of practice under state law.
	Outpatient occupational therapy provided in a certified rehabilitation center is covered only when billed by the rehabilitation center.	
	In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	More than one evaluation visit in a six-month period requires authorization.
	Occupational therapy services are covered in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries.	
	Outpatient occupational therapy services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: audiology, acupuncture, chiropractic, psychology, podiatry, and speech therapy.	TAR is required for an occupational therapy visit that exceeds the two-visit limit.
	Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services.	

*Prior Authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance and acquisition of skills and audiology may be provided only upon the written prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity.	Services must be performed by providers who meet the applicable qualification requirements as defined for speech therapy and audiology services in 42 CFR Section 440.110(c), licensed and within their scope of practice under state law.
	Speech therapy and audiology provided in a certified rehabilitation center is covered only when billed by the rehabilitation center.	
	In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	More than one evaluation visit in a six-month period requires authorization.
	Speech therapy and audiology services are covered in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries.	
	Speech therapy and audiology services are covered under this state plan only for the following beneficiaries: 1. Pregnant women, if the speech therapy and audiology services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program.	

*Prior Authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology (Cont)	Outpatient speech therapy and audiology services are subject to a two-services limit in any one calendar month or any combination of two services per month from among the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, chiropractic, occupational therapy, podiatry, and psychology. Effective January 1, 2014, the two-visit limit does not apply to psychology services. See Item 6d.1 regarding psychology services.	TAR is required for a speech therapy or audiology visit that exceeds the two-visit limit.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12a Pharmaceutical services and prescribed drugs	Covered when prescribed by a licensed practitioner. Drugs for the treatment of hospital inpatients are covered as encompassed in the formulary of the hospital. Drugs administered for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are covered, but payable only when included in the all-inclusive rate.	Prior authorization is not required for drugs listed in the Drug Formulary except that certain Formulary drugs are subject to prior authorization unless used as specified therein. Except for hospital inpatients, prescriptions shall not exceed a 100-calendar-day supply. Hospital inpatient drugs, as encompassed in the Formulary of the hospital, do not require prior authorization. Hospital discharge medications may not exceed a ten-day supply. Certain Formulary drugs are subject to minimum or maximum quantities to be supplied. Drugs not on the Drug Formulary are subject to prior authorization, except that certain drugs are excluded from Medi-Cal program coverage. Six- prescription-per-month-limit. Additional prescriptions will be available through the "prior authorization" process. The limit shall not apply to patients receiving care in a nursing facility or to drugs for family planning.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b. Dentures	See 10.	See 10.
12c. Prosthetic and orthotic applicances, and hearing aids	Prosthetic and orthotic appliances are covered when prescribed by a physician or podiatrist. Stock shoes (conventional or orthopedic) are covered when at least one of the shoes is to be attached to a prosthesis or brace. Orthopedic modifications to stock shoes are also covered.	Prior authorization is required when the purchase price is more than $100. Prior authorization is required for rental or repair when the total cost is more than $50.
	Prosthetic eyes are covered when prescribed by a physician or other licensed practitioner performing within his or her scope of practice.	Prior authorization is required for prosthetic eyes and most prosthetic eye services.
	Hearing aids are covered only when supplied by a hearing aid dispenser upon the prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available. Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered. Replacement of hearing aids that are lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control is not included in the $1,510 maximum benefit cap. Hearing aid benefits are subject to a $1,510 maximum cap per beneficiary per fiscal year. Hearing aid benefits include hearing aids and hearing aid supplies and accessories. The following beneficiaries are exempted from the cap: • Pregnant women, if hearing aids are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. • Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.	Prior authorization is required for the purchase or trial period rental of hearing aids and for hearing aid repairs which exceed a cost of $25. Cords, receivers, ear molds, and hearing aid garments are covered without prior authorization.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the written prescription of a physician or an optometrist under this state plan only for the following beneficiaries: Pregnant women, if eyeglasses or other eye appliances are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of eyeglasses. Prior authorization is required for ophthalmic lenses and frames that cannot be supplied by the fabricating optical laboratory.
13a Diagnostic services	Covered under this state plan only for EPSDT program	
13b Screening services	Covered under this state plan only for EPSDT program	
13c Preventive services	Covered for all preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Preventive services are provided and covered by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services. The State assures that the benefit package will be updated as changes are made to USPSTF and ACIP recommendations, and that the State will update the coverage and billing codes to comply with these revisions.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

State Plan Chart

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13d.1	(Intentionally left blank)	***	
13d.2	(Intentionally left blank)		
13d.3	(Intentionally left blank)		
13d.4	Rehabilitative mental health services for seriously emotionally disturbed children	See 4b EPSDT program coverage.	Medical necessity is the only limitation.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services
*** The elimination of Adult Day Health Care previously scheduled to take place on 3/1/12 (approved via SPA 11-035) has been postponed and will be effective as of 4/1/12.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	See Supplement 3 to Attachment 3.1-A for program coverage and eligibility details.	Services are based on medical necessity and in accordance with a client plan signed by a licensed mental health professional. Beneficiaries must meet medical necessity criteria.
13.d.5 Substance Use Disorder Treatment Services	Substance use disorder treatment services include: Narcotic treatment program (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Naltrexone Treatment (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.
**Coverage. is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Outpatient Drug Free Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. In cases where additional EPSDT services are needed for individuals under 21, these services are available subject to prior authorization. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Intensive Outpatient Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Perinatal Residential Substance Use Disorder Services (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. The cost of room and board are not reimbursable DMC services.
	Substance Use Disorder Treatment Services provided to Pregnant and Postpartum Women (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.
***Outpatient services are pursuant to 42 CFR 440.130.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Perinatal Residential Substance Use Disorder Services (see Supplemental 2 To Attachment 3.1-A for program coverage and details under Extended Services For Pregnant Women)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. Room and board are not reimbursable DMC services.
	Substance Use Disorder Treatment Services Provided to Pregnant and Postpartum Women (see Supplemental 2 To Attachment 3.1-A for program coverage and details under Extended Services For Pregnant Women)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.
**Coverage. is limited to medically necessary services.

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
14.a. Services for individuals age 65 or older in institutions for tuberculosis	See 1, 4a, 15	See 1, 4a, 15.
14.b. Services for individual age 65 or older in institutions for mental diseases	See 1, 4a, 15.	See 1, 4a, 15.

* Prior authorization is not required for emergency services.
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TYPE OF SERVICE		PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15	Nursing facility level A	Covered when patient is under the care of a physician who because of mental or physical conditions or both (above the level of board and care) requires out-of-home protective and supportive care living arrangements with 24-hour supervision and skilled nursing care on an ongoing intermittent basis. The patient must be visited by a physician at least every 60 days.	Prior authorization is required. The patient physician must recertify patient's need for continued care every 60 days.
15a	ICF services for the developmentally disabled (ICF-DD), ICF-DD Habilitative (ICF DD-H), or ICF-DD Nursing (ICF DD-N)	Covered only for developmentally disabled persons who require 24-hour care in a protected setting and who require and will benefit from the services provided. The developmentally disabled nursing services are for those who are more medically fragile.	Prior authorization is required. The patient physician must recertify patient's need for continued care on the same schedule as required for ICFs.
16	Inpatient psychiatric facility services for individuals under 22 years of age	Inpatient psychiatric services in an institution for mental diseases are covered under this state plan for persons under age 21 or in certain circumstances up to the 22 years of age when the inpatient treatment is initiated prior to reaching 21 years of age. See "1 Inpatient Hospital Services."	Prior authorization is required for all non-emergency hospitalizations. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization. Emergency admission requires a statement from a physician or practitioner performing within his or her scope of licensure to support the emergency admission. See "1 Inpatient Hospital Services."

*Prior authorization is not required for emergency service
**Coverage is limited to medically necessary services

(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
17. Nurse Midwife Services	All services permitted under scope of licensure.	Services do not require prior authorization.
18. Hospice Services	Covered when provided by a Medicare certified hospice in the same scope and duration as Medicare. Services are limited to individuals who have been certified by a physician as having a life expectancy of six months or less.	Prior authorization is required for general inpatient care. Special physicians services do not require prior authorization. Eligible adults electing hospice care agree to waive their right to receive curative services related to their terminal illness. Eligible children electing hospice care can receive concurrent palliative and curative care.

* Prior authorization is not required for emergency service
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1f to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria.	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself which do not meet the definition of targeted case management • Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management • Diagnostic and/or treatment services • Services which are an integral part of another service already reimbursed by Medicaid • Restricting or limiting access to services, such as through prior authorization • Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determination or claims processing

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	TYPES OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
19b	Special Outpatient Tuberculosis-Related	Services designed to encourage the completion of regimens of prescribed drugs by outpatients, including services to directly observe the intake of prescribed drugs (directly observed therapy (DOT)). Dot includes; delivery of prescribed medications; assisting with the means to ingest medications; monitoring for signs of nonadherence or adverse side effects; documenting that medications have been ingested; and reporting compliance and/or other problems.	Prior authorization is not required.

* Prior authorization is not required for emergency services
**Coverage is limited to medically necessary services

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	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 60th 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	Ambulatory prenatal care to pregnant women provided during a single limited period of presumptive eligibility. The scope of benefits is limited to specified outpatient pregnancy related services and does not include abortion or labor and delivery services.	Prior authorization is not required.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

	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.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
24a.	Medical transportation services	Covered when transport by ordinary means is medically contraindicated and the transportation is required for covered medical care, subject to limitation. Only the lowest cost type of medical transportation adequate for the patient's needs is covered.	All nonemergency transportation requires prior authorization and a physician's, dentist's or podiatrist's written prescription. Emergency claims must be accompanied by justification.
24b.	Christian Science practitioners	Limited to the extent allowed under Title XVIII of the Social Security Act.	Services are subject to the two services per month limitation. See 6c.
24c.	Christian Science sanitoria care and services	See 4a.	See 4a.
24d.	SNF services provided for patients under 21 years of age	See 4a.	See 4a.
24d.1	Transitional Inpatient Care (TC) (Nursing Facility)	See 4a.3.	See 4a.3.
24e.	Emergency hospital services	See 1.	See 1.
24f.	Personal care services	Not covered.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services	LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus. LEA services are defined as: Non-IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.	Service Limitations LEA services are limited to a maximum of 24 services per 12-month for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student, • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management). All Medi-Cal recipients have access to enrolled LEA providers for the services they provide.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.	Provider Qualifications Services must be performed by providers who meet the applicable qualification requirements as defined in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed speech-language pathologists (formerly credentialed language, speech and hearing specialists), credentialed audiologists (formerly credentialed language, speech and hearing specialists), licensed physical therapists, registered occupational therapists, and registered dieticians. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110. In addition, the following limitations apply: • Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services (cont.)	<u>Treatment Services</u> • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 4 (b) and 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); Medical transportation (as covered in Subsection 24(a).	• Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students. • Credentialed audiologists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of a licensed audiologist only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students.

*Prior Authorization is not required for emergency service.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services (cont.)		• Credentialed speech-language pathologists who have a preliminary or professional clear services credential in speech-language pathology may provide assessments and treatment services related to speech, voice, language, or swallowing disorders, for which a student has been referred by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students. Credentialed speech-language pathologists who do not have a preliminary or professional clear services credential in speech-language pathology may provide services under the direction of a licensed speech-language pathologist or a credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110. • Credentialed pupil service workers may provide psychosocial assessments only; • Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only; • School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services (cont.)		• _The definition of "under the direction of" a licensed audiologist, licensed speech-language pathologist or credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology is that the practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed practitioners that he or she agrees to direct. The practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

*Prior Authorization is not required for emergency service.

**Coverage is limited to medically necessary services.

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
25. Personal Care	Personal Care Services authorized by the county worker are based on an assessment of the recipient. Qualified providers shall perform services in the recipient's home or at place of employment. Services may include one or more activities such as assisting with the administration of medications, providing needed assistance or supervision with basic personal hygiene, eating, grooming and toileting. Other incidental services may also be provided as long as they are subordinate to personal care services.	Personal Care Services shall be available to all categorically needy eligibles covered under the state plan and in accordance with state law. Services will be provided to the recipients who have an illness that has been diagnosed to be chronic and/or permanent (lasting at least one year) and who are unable to remain safely at home or are unable to obtain, retain or return to work without this assistance. Personal Care Service hours shall be capped at a maximum of 283 hours per month. Service hours for recipients shall be based on medical necessity as determined by the Statewide Uniform Assessment. Services in support of work are only available to the extent that service hours utilized at work are included in the total personal care service hours authorized for the recipient based on the recipient's need for services in the home. Authorized personal care services utilized by a recipient for work shall be services that are relevant and necessary in supporting and maintaining employment and shall not supplant any reasonable accommodation required of an employer under the Americans with Disabilities Act or other legal entitlements or third-party obligations. Services shall not be available to residents of a facility licensed by the California State Department of Health Services nor to residents of a community care facility or a residential care facility licensed by the California State Department of Social Services Community Care Licensing Division.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
27. Program for All-Inclusive Care for the Elderly (PACE)	PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE services package includes all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team essential for the care of the enrollee. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and shall provide enrollees access to necessary and covered items and services 24 hours per day, every day of the year.	PACE services shall be available to eligible individuals who meet the age criteria of 55 years old or older, reside in the service area of the PACE program, are certified as eligible for nursing home care by the California Department of Health Services, and meet other eligibility conditions as may be imposed under the PACE program agreement.

**Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE*	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
29.a Licensed or otherwise State-approved Alternative Birth Centers.	All services permitted under scope of licensure. Obstetrical and delivery services throughout pregnancy and through the end of the month following 60 days after the pregnancy ends.	Must be certified as a Comprehensive Perinatal Services Program provider, or certified within the first year of operation.
29.b Licensed or otherwise State-recognized covered professionals providing services in the Alternative Birth Center.		
	b.1 Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan.	Physicians, including general practitioners, family practice physicians, pediatricians, and obstetric-gynecologists; and certified nurse midwives; as licensed by the State.
	b.2 Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in an alternative birth center within the scope of practice under State law.	Certified nurse practitioners must be under the supervision of a physician and licensed by the State.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.