



Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DEC 19 2011

Toby Douglas, Director
Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 11-023, which responds to a companion letter sent with the approval of 09-001 dated May 23, 2011. The SPA is effective July 1, 2011.

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

Limitations on Attachment 3.1-A, pages 16 & 21

Limitations on Attachment 3.1-B, pages 16 & 21

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

Sincerely,

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

Enclosure

cc: Melissa Musotto, Centers for Medicare and Medicaid Services
Vicki Orlich, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-023	2. STATE California
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FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: Social Security Act (Medicaid)
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TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2011
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5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

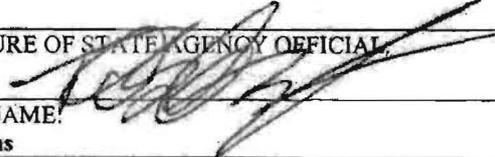
6. FEDERAL STATUTE/REGULATION CITATION: 42 U.S.C. 1396a, 42 CFR Part 440	7. FEDERAL BUDGET IMPACT: N/A
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Limitations on Attachment 3.1-A Page 16 Limitations on Attachment 3.1-B Page 16 Limitations on Attachment 3.1-A Page 21 Limitations on Attachment 3.1-B Page 21	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Limitations on Attachment 3.1-A Page 16 Limitations on Attachment 3.1-B Page 16 Limitations on Attachment 3.1-A Page 21 Limitations on Attachment 3.1-B Page 21
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10. SUBJECT OF AMENDMENT:
Response to comments on the companion letter dated May 23, 2011 – amendments to psychiatric services for beneficiaries under 21 year and physical therapy and related services.

11. GOVERNOR'S REVIEW (Check One):

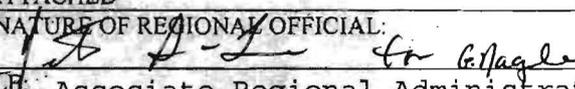
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor's Office does not
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.3.26 P.O. Box 997417 Sacramento, CA 95899-7417
13. TYPED NAME: Toby Douglas	
14. TITLE: Director	
15. DATE SUBMITTED: SEP 20 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 20, 2011	18. DATE APPROVED: DEC 19 2011
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Gloria Nagle	22. TITLE: Associate Regional Administrator

23. REMARKS:

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11 Physical Therapy and related services	<p>Physical therapy and occupational therapy are covered only when prescribed by a physician, dentist, or podiatrist. Speech therapy and audiology may be provided only upon the written prescription of a physician or dentist.</p> <p>Outpatient physical therapy, occupational therapy, speech therapy, and audiology provided in a certified rehabilitation center are payable only when billed by the rehabilitation center. Maintenance therapy services are covered for beneficiaries under the age of 21 years, when medically necessary.</p> <p>Speech therapy and audiology services are covered under this state plan only for the following beneficiaries:</p> <p style="padding-left: 40px;">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 the pregnancy.</p> <p style="padding-left: 40px;">Individual who is an eligible beneficiary under the Early and Periodic Screening Diagnosis and Treatment Program</p>	<p>All physical therapy services are subject to prior authorization.</p> <p>Services must be performed by providers who meet the applicable qualification requirements as defined for physical therapy in 42 CFR Section 440.110(a), occupational therapy in 42 CFR Section 440.110(b), and speech therapy and audiology services in 42 CFR Section 440.110(c), licensed and within their scope of practice under state law.</p> <p>Occupational therapy, speech therapy, and audiology services rendered by independent practitioners at outpatient settings are limited to a maximum of two services per month and require prior authorization. Services are subject to the Medi-Service reservation, except that these services, when rendered to patients in SNFs or ICFs are subject to prior authorization. Services are covered for beneficiaries under the age of 21 years when medically necessary, and are subject to prior authorization.</p> <p>In a certified rehabilitation center, one visit in a six month period for evaluation of the patient and preparation of an extended treatment plan may be provided without prior authorization. Additional services including other evaluation can be provided in accordance with an approved treatment plan signed by a physician subject to prior authorization.</p>

TN No. 11-023

Supersedes TN No. 09-001

Approval Date: DEC 19 2011

Effective Date: 7/1/11

* 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*
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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*
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	<p>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.</p> <p>See "1 Inpatient Hospital Services."</p>	<p>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.</p> <p>Emergency admission requires a statement from a physician or practitioner performing within his or her scope of licensure to support the emergency admission.</p> <p>See "1 Inpatient Hospital Services."</p>

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**Coverage is limited to medically necessary services

TN No. 11-023

Supersedes

TN No. 09-001

Approval Date DEC 19 2011

Effective Date: 7/1/11

STATE PLAN CHART

(Note: This chart is an overview only)

Limitations on Attachment 3.1-B

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	<p>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.</p> <p>See "1 Inpatient Hospital Services."</p>	<p>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.</p> <p>Emergency admission requires a statement from a physician or practitioner performing within his or her scope of licensure to support the emergency admission.</p> <p>See "1 Inpatient Hospital Services."</p>

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 **Coverage is limited to medically necessary services

ENCLOSURE

**FOR STAKEHOLDERS ONLY

Revised Pages for:
CALIFORNIA MEDICAID STATE PLAN
Under Transmittal of
STATE PLAN AMENDMENT (SPA)
11-023*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page(s)
Limitations on Attachment 3.1-A, page 16	Limitations on Attachment 3.1-A, page 16
Limitations on Attachment 3.1-B, page 16	Limitations on Attachment 3.1-B, page 16
Limitations on Attachment 3.1-A, page 21	Limitations on Attachment 3.1-A, page 21
Limitations on Attachment 3.1-B, page 21	Limitations on Attachment 3.1-B, page 21

