

(Note: This chart is an overview only.)

Limitations on Att. 3,
31-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 Inpatient hospital services	<p>Inpatient services are covered as medically necessary except that services in an institution for mental diseases are covered only for persons under 21 years of age or for persons 65 years of age and over.</p> <p>Services in an institution for tuberculosis for persons under 65 are not covered.</p> <p>Services in the psychiatric unit or TB unit of a general hospital are covered for all age groups.</p>	<p>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.</p> <p>Emergency admissions require a physician's, dentist's, or podiatrist's statement supporting the admission.</p> <p>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.</p> <p>Mental health services are identified in the Short-Doyle/Medi-Cal (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 or the SD/MC system.</p>

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH # 88-117

Eff 7-1-88

App. MAR 21 1988

STATE PLAN CHART

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)	<p>TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital.</p> <p>Medical necessity includes, but is not limited to, one or more of the following:</p> <ol style="list-style-type: none"> 1. Intravenous therapy, including but not limited to: <ul style="list-style-type: none"> • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration <p>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.</p>	<p>Prior authorization is required for TC level of care.</p> <p>The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care.</p> <p>A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management.</p> <p>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.</p>

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN NO. 96-01
SUPERSEDES
TN NO. _____

APPROVED DATE JAN 31 1997

EFFECTIVE DATE JAN 01 1996

STATE PLAN CHART

Limitations on Attachment 3-1-B

Page 1.2

Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)</p>	<p>2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to:</p> <p>A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria:</p> <ul style="list-style-type: none"> • 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 	<p>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 a physician, may provide non-duplicative services to TC patients.</p> <p>Leave of absence is covered for TC Rehabilitation patients only.</p> <p>TC patients require care by registered nurses on every shift.</p>

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

IN NO. TC-004
~~96-01~~
 SUPERSEDES
 IN NO. _____

APPROVED DATE JAN 31 1997

EFFECTIVE DATE JAN 01 1996

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 1, 3

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)	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN NO. 96-01
 SUPERSEDES
 TN NO. _____

APPROVED DATE JAN 31 1997

EFFECTIVE DATE JAN 01 1996

Note: This chart is an overview only.)

STATE PLAN CHART

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.	

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

IN NO. 16-004
~~96-01~~
 SUPERSEDES
 IN NO. _____

APPROVED DATE JAN 31 1997

EFFECTIVE DATE JAN 01 1996

ST PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a Hospital outpatient department services and organized outpatient clinic services	<p>The following services are covered:</p> <ol style="list-style-type: none"> 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 physicians' services 19. Family planning 20. Adult day health care 	<p>Prior authorization is always required for physical therapy; chronic hemodialysis; purchase, rental, or repair of hearing aids if cost exceeds \$25; adult day health care; surgical procedures considered to be elective; outpatient heroin detoxification; outpatient procedures such as hyperbaric O₂ therapy, psoriasis day care, plasmapheresis, and cardiac catheterization.</p> <p>Prior authorization is required for psychiatric visits in excess of 8 in 120 days and for allergy injections in excess of 8 in 120 days. Speech pathology and audiology, occupational therapy, acupuncture, and psychology services are subject to the availability of MEDI lab. Routine podiatry office visits are allowed without prior authorization. All other podiatry services are subject to prior authorization.</p> <p>Prior authorization is required when the purchase price of durable medical equipment or prosthetic orthotic appliances exceeds \$100.</p> <p>Prior authorization is required when cumulative purchase price of durable medical equipment, prosthetic orthotic appliances, or repairs exceeds \$25.</p>

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SP1141 88 17

EFF 7-1-88

App. MAR 21 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b Rural health clinic services and other ambulatory services courses under the state plan.	Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	All services, including physicians' services are subject to the same requirements as when provided in a nonfacility 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 or the SD/MC system. Home nursing services must be furnished in accordance with a written treatment plan established by a physician or nonphysician medical practitioner. The treatment plan must be approved and reviewed every 60 days by the supervising clinic physician.
2c Federally qualified health center (FQHC) services and other ambulatory services covered under the state plan.	Physician services and home nursing services provided by a FQHC.	All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting. All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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 performed 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. The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	Prior authorization is required. Attending physicians must recertify a patient's level of care and plan every 60 days. For patients having Medicare as well as Medicaid eligibility (crossover cases), authorization required at the time of Medicare denial or <u>before</u> the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH # 88-17

EFF 7-1-88

App MAR 31 1988

STA PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.1 Subacute care services (SNF)	<p>This is a more intensive SNF level of care.</p> <p>Covered when patient has need for intensive licensed skilled nursing care.</p> <p>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.</p> <p>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.</p>	<p>Same as 4a above.</p> <p>Initial care may be authorized for up to two months.</p> <p>Prolonged care may be authorized for up to a maximum of four months.</p>

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH-4 58-17

EFF 7-1-88

App 1 1989

ST E PLAN CHART

(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.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH#100-17

EFF 1-1-88

App. MAR 21 1989

STANDARD PLAN CHART

(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:	<ol style="list-style-type: none"> 1. Traction and pin care for fractures (this does not include Bucks Traction). 2. Total parenteral 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.

STA PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	<p>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.</p>	
	<p>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).</p>	
	<p>9. Debridement, packing, and medicated irrigation with or without whirlpool treatment.</p>	
	<p>10. Continuous mechanical ventilation for at least 50 percent of each day.</p>	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #186-17

EFF 7-1-88

App MAR 21 1988

(Note: This chart is an overview only.)

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 8.1

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.2 Pediatric subacute services (NF)	<p>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.</p> <p>Covered when medical necessity is substantiated as follows:</p> <p>Patient requires any one of the following items in 1-4 below:</p> <ol style="list-style-type: none">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:	<p>Same as 4a above.</p> <p>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.</p>

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

TN 94-024
SUPERSEDES TN 94-003

APPROVED DATE 5/5/98

EFFECTIVE DATE 10/1/99

(Note: This chart is an overview only.)

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 8.2

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	<p>A. Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;</p> <p>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;</p> <p>C. Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;</p>	

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

N 94-024
UPERSEDES TN 94-003

APPROVED DATE 5/5/98

EFFECTIVE DATE 10/1/94

(Note: This chart is an overview only.)

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 8.3

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.

TN 94-024
SUPERSEDES TN 94-003

APPROVED DATE 5/5/98

EFFECTIVE DATE 10/1/94

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 8.4

(Note: This chart is an overview only.)

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);

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN 94-024
SUPERSEDES TN 94-003

APPROVED DATE 5/5/98

EFFECTIVE DATE 10/1/94

(Note: This chart is an overview only.)

STATE PLAN CHART

Limitations on Attachment 3-1-B
Page 8.5

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.

TN 94-024
SUPERSEDES TN 94-003

APPROVED DATE

5/5/98

EFFECTIVE DATE

10/1/94

STATE PLAN CHART

(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.

TN NO. 96-001
SUPERSEDES
TN NO. _____

APPROVED DATE 6/11/99

EFFECTIVE DATE 1/1/96

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.

Covered for Medi-Cal eligibles under 21 years of age.

Prior authorization is not required.

Includes rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day care intensive, day care habilitation offered in local and mental health clinics or in the community.

Medical necessity is the only limitation.

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

LEA services 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 LEA services 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 service.
**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: <u>Non-IEP/IFSP Assessments</u> <ul style="list-style-type: none">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. <u>Provider Qualifications</u> 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 language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dietitians.

*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*
<p>4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.</p> <p>Local Education Agency (LEA) Services (cont.)</p>	<p><u>IEP/IFSP Assessments</u></p> <ul style="list-style-type: none"> 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. 	<p>In addition, the following limitations apply:</p> <ul style="list-style-type: none"> 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.

*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*
<p>4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.</p> <p>Local Education Agency (LEA) Services (cont.)</p>	<p><u>Treatment Services</u></p> <ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • Credentialed language, speech and hearing specialists 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 licensed speech pathologists or licensed audiologists 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. <p>The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed 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.</p>

*Prior Authorization is not required for emergency service.

**Coverage is limited to medically necessary services.

TN No. 03-024
Supercedes
TN No. 00-026

Approval Date MAR 14 2005

Effective Date APR 01 2003

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
<p>4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.</p> <p>Local Education Agency (LEA) Services (cont.)</p>		<ul style="list-style-type: none"> • 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. <p>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.</p>
<p>4c Family planning services and supplies for individuals of child bearing age.</p>	<p>Covered as physician and pharmaceutical services.</p>	<p>Prior authorization is not required, and informed consent must be properly obtained for all sterilizations. Sterilization of persons under 21 years of age is not covered.</p>
<p>5a Physician's Services</p> <p>*Prior Authorization is not required for emergency service. **Coverage is limited to medically necessary services.</p>	<p>As medically necessary, subject to limitations; however, experimental services are not covered.</p>	<p>Physician services do not require prior authorization except as noted below:</p>

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 10

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	<p>Procedures generally considered to be elective must meet criteria established by the Director.</p> <p>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.)</p> <p>Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.</p>	<p>Outpatient medical procedures such as hyperbaric O₂ therapy, psoriasis day care, apheresis, cardiac catheterization, 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.</p> <p>Prior authorization is required for psychiatric services in excess of 8 services in each 120-day period and 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.</p>

* 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.

TN No. 00-026
Supersedes TN No. 93-014

Approval Date: AUG 27 2001

Effective Date: OCT - 1 2000

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 10a

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>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.</p>	<p>In accordance with 42 U.S.C. Section 1396d (a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.</p>	<p>Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, 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.</p>

* 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.

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 10b

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>Medical care and any other type of remedial care recognized under State law.</p> <p>6a. Podiatrists' services.</p>	<p>Routine nail trimming is not covered.</p> <p>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.</p> <p>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.</p>	<p>Routine office visits do not require prior authorization. All other podiatry services are subject to prior authorization, except emergencies.</p> <p>All services provided in SNFs and ICFs are subject to prior authorization.</p>

* 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.

ST PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6b Optometry services	As medically necessary except that orthoptics and pleoptics are not covered. Routine eye examinations with refraction are limited to one service in a 24-month period.	Prior authorization is necessary for low vision aids when the billed amount is over \$100 and for contact lenses if they are the extended type or the contacts are to correct anisometropia or when facial pathology or deformity preclude the use of eyeglasses. Payment for some procedures may require additional justification.
6c Chiropractic services	Limited to manual manipulation of the spine.	Prior authorization is not required; however, services are limited to a total of two services or any combination of two services in any one month from among the following: chiropractic, acupuncture, psychology, occupational therapy, speech pathology, and audiology.
6d.1 Psychology	Psychology services are covered subject to the availability of MEDI labels.	
6d.2 Nurse anesthetist services	Nurse anesthetists may administer all types of anesthesia within their scope of licensure.	Since rendered as an adjunct to a physician, clinic, or hospital service, separate authorization is not required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 4-88 17

EFF 7-1-88

AA

MAR 22 1988

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*
6d3 Acupuncture services	Covered to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition.	Same as 6c.
6d.4 Licensed midwife services	All services permitted under scope of licensure.	Limited to the care of mothers and newborns during the maternity cycle, which consists of pregnancy, labor, birth, and a six-week postpartum period; and when performed under the supervision of a licensed physician and surgeon. Prior authorization for some services is required when applicable.
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.	Covered when prescribed by a physician in the home of a beneficiary in accordance with a written treatment plan. The patient's condition must require skilled nursing care or other therapeutic services.	
7a. Home health nursing 7b. and aide services		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.

TN No. 02-012

Supersedes TN No. 88-17

Approval Date: JUN -7 2002

Effective Date: JUL 1 2002

* Prior authorization is not required for emergency service.

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #88-17

Eff 7-1-88

App

NOV 1 1989

STATE CHART

Attachment 3.1-B

(Note: This chart is an overview only)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	<p>Covered when prescribed by a licensed practitioner.</p> <p>DME commonly used in providing SNF and ICF level of care is not separately billable.</p> <p>Common household items are not covered.</p>	<p>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.</p> <p>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.</p>
7c.3	Hearing aids	<p>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.</p> <p>Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered.</p>	<p>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</p> <p>Authorization for hearing aids may be granted only when tests reveal an average loss of 35 dB or greater, or if the difference between the level of 1,000 Hertz and 2,000 Hertz is 20 dB or more. The hearing loss need only be 30 dB, and speech communication is effectively improved or the need for personal safety is met.</p>
7c.4	Enteral Formulae	<p>Covered only when supplied by a pharmacy provider upon the prescription of a licensed practitioner within the scope of his or her practice.</p> <p>Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable.</p> <p>Common household items (food) are not covered.</p>	<p>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.</p> <p>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.</p>

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN 03-12
Supersedes
TN 88-017

Approval date JAN - 2 2004

Effective date: January 1, 2003

STATE PAYMENT CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 15

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d	Physical and occupational therapy, speech pathology and audiology services provided by a home health agency.	See 11.	See 11.
8	Special duty nursing services.	Not covered.	
9	Clinic services	See 2a.	See 2a.
10	Dental services	<p>Pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, subject to limitations contained in applicable state statutes, regulations, manual of criteria, and utilization controls.</p> <p>Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits.</p> <p>For beneficiaries 21 years of age and older, there is an \$1,800 annual benefit maximum, with the following exceptions:</p> <ul style="list-style-type: none"> • Emergency dental services • Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and for other conditions that might complicate the pregnancy. 	<p>Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI), subject to state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization of a defined subset of dental services is required.</p>

STATE FUND CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 15a

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	<ul style="list-style-type: none"> • Dentures • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses. • Services provided in long-term care facilities. 	
	<p>For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Act (42 U.S.C. Sections 1396d(a)(4)(B) and (r), early and periodic screening, diagnostic, and treatment services are covered.</p>	

* 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.

STAT PLAN CHART

(Note: This chart is an overview only.)

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 pathology 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 not covered.</p>	<p>All physical therapy services are subject to prior authorization.</p> <p>Occupational therapy, speech pathology, and audiology services rendered by independent practitioners are subject to the availability of MEDI labels, except that these services, when rendered to patients in SNFs or ICFs 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>

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

APP MAR 21 1989

SPH # 88-17

EFF 7-1-88

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12a Pharmaceutical services and prescribed drugs	<p>Covered when prescribed by a licensed practitioner.</p> <p>Drugs for the treatment of hospital inpatients are covered as encompassed in the formulary of the hospital.</p> <p>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.</p>	<p>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.</p> <p>Except for hospital inpatients, prescriptions shall not exceed a 100-calendar-day supply.</p> <p>Hospital inpatient drugs, as encompassed in the Formulary of the hospital, do not require prior authorization.</p> <p>Hospital discharge medications may not exceed a ten-day supply.</p> <p>Certain Formulary drugs are subject to minimum or maximum quantities to be supplied.</p> <p>Drugs not on the Drug Formulary are subject to prior authorization, except that certain drugs are excluded from Medi-Cal program coverage.</p> <p>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.</p>

* 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.)

Limitations on Attachment 3.1-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b Dentures	See 10.	See 10.
12c Prosthetic and orthotic appliances	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. Custom-made orthopedic shoes may be authorized when there is a clearly established medical need that cannot be satisfied by the modification of stock orthopedic shoes.
12d Eyeglasses, prosthetic eyes, and other eye appliances	Covered as medically necessary on the written prescription of a physician or optometrist.	Prior authorization is required for some vision aids and contact lenses.
13a Diagnostic services	See 4b	
13b Screening services	See 4b	
13c Preventive services	See 4b EPSDT program coverage. Covered services for pregnant/postpartum Medi-Cal recipients etc.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

TN No. 91-12 supersedes TN No. 88-17

April 1, 1991

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*	
13d.1	Adult day health care	Covered when requested by a physician for elderly persons or other adults with mental or physical impairments which handicap daily living activities, require treatment, or rehabilitative services but which are not of such a serious nature as to require 24-hour nursing care.	Prior authorization is required. Requests for authorization must be accompanied by a multidisciplinary team assessment which ascertains the individual's pathological diagnosis, physical disabilities, functions, abilities, psychological status, and social and physical environment.
13d.2	Chronic dialysis services	Covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Home dialysis and continuous ambulatory peritoneal dialysis are covered.	Prior authorization is required for the facility but not the physician. Initial authorization may be granted up to three months. Reauthorization may be granted up to 12 months. Inpatient hospitalization for patients under going dialysis requires prior authorization.
13d.3	Outpatient heroin detoxification services.	Daily treatment is covered through the 21st day.	Prior authorization is required. Additional charges may be billed for services medically necessary to diagnose and treat diseases which the physician believes are concurrent with, but not part of, the outpatient heroin detoxification services.
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. Services are available equally to the categorically needy and medically needy.

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*
13.d.4 Rehabilitative mental health services (continued)	Short-Doyle/Medi-Cal rehabilitative mental health services are provided in the least restrictive setting appropriate for maximum reduction of psychiatric impairment, restoration of functioning consistent with requirements for learning and development, and/or independent living and enhanced self-sufficiency.	Services are based on medical necessity and in accordance with a coordinated client plan signed by a licensed practitioner of the healing arts.
13.d.5 Substance Abuse Treatment Services	<p>Narcotic treatment program services, including outpatient methadone maintenance and/or levoalphacetylmethadol (LAAM), are covered under Drug Medi-Cal (DMC) when prescribed by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids.</p> <p>Naltrexone provided as an outpatient treatment service directed at serving detoxified opioid addicts is covered under DMC when prescribed by a physician as medically necessary. Pregnant beneficiaries are precluded from receiving these services.</p>	<p>Prior authorization is not required. Post-service periodic reviews are conducted by the Department of Alcohol and Drug Programs (ADP) pursuant to an interagency agreement with the Department of Health Services (DHS), the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.</p> <p>Same as above.</p>

* 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-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
<p>13.d.5 Substance Abuse Treatment Services (continued)</p>	<p>Outpatient drug free treatment services to stabilize and rehabilitate patients who have a substance-related disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.</p> <p>Day care rehabilitative treatment services provided to patients a minimum of three hours per day, three days a week, are covered under DMC when prescribed by a physician as medically necessary.</p> <p>See Supplement 2 to Attachment 3.1-A and Enclosure 1 for a description of substance abuse treatment services for pregnant and postpartum women.</p>	<p>Same as above, except in those cases where additional EPSDT services (beyond those available under ADP regulations) are needed for individuals under 21, services are available subject to prior authorization by DHS.</p> <p>Prior authorization is not required. Post-service periodic reviews are conducted by ADP pursuant to an interagency agreement with DHS, the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.</p>

* 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-B

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.
 ** Coverage is limited to medically necessary services.

STAT LAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15 ICF services	Covered when patient is under the care of a physician and requires out-of-home protective 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, developmentally disabled, developmentally disabled, or developmentally disabled nursing	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	See 1.	See 1.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPW #88-17

EFF 7-1-88

App MAR 21 1989

STATE PLAN CHART

(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 each of the four levels of hospice care described in regulation: routine home care, continuous home care, inpatient respite care, and general inpatient care. Special physicians services do not require prior authorization. Persons electing hospice care agree to waive their right to receive curative services related to their terminal illness.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN NO. 96-001
SUPERSEDES
TN NO. 88-17

APPROVED DATE 6/11/99

EFFECTIVE DATE 1/1/96

STATE PLAN CHART

(Note: This chart is an overview only.)

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: <ul style="list-style-type: none"> • 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.

TN NO. 96-001
 SUPERSEDES
 TN NO. 95-006

APPROVED DATE 6/11/99

EFFECTIVE DATE 1/1/96

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 23b

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

TN No. 94-012

Supersedes

TN No. NONE

Approval Date 4/25/96

Effective Date 10/1/99

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B
Page 24

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	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.

TN No. 93-015
Supersedes
TN No. _____

Approval Date MAR 22 1994

Effective Date OCT 01 1993

STATE PLAN CHART

Limitations on Attachment 3-1-B

Page 24.1

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
23a. 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.
23b. 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.
23c. Christian Science sanatoria care and services	See 4a.	See 4a.
23d. SNF services provided for patients under 21 years of age	See 4a.	See 4a.
23d.1 Transitional Inpatient Care (TC) (Nursing Facility)	See 4a.3.	See 4a.3.
23e. Emergency hospital services	See 1.	See 1.
23f. Personal care services	Not covered.	

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN NO. 96-001

SUPERSEDES

TN NO. 88-17

APPROVED DATE

6/11/99

EFFECTIVE DATE

1/1/96

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services	<p>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.</p> <p>LEA services are defined as:</p> <p><u>Non-IEP/IFSP Assessments</u></p> <ul style="list-style-type: none">• 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.	<p><u>Service Limitations</u></p> <p>LEA services 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 LEA services beyond 24 services per 12-month period from the beneficiary's:</p> <ul style="list-style-type: none">• 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). <p>All Medi-Cal recipients have access to enrolled LEA providers for the services they provide.</p>

*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*
23g Local Education Agency (LEA) Services (cont.)	<p><u>IEP/IFSP Assessments</u></p> <ul style="list-style-type: none">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.	<p><u>Provider Qualifications</u></p> <p>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 language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dieticians.</p> <p>In addition, the following limitations apply:</p> <ul style="list-style-type: none">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*
23g Local Education Agency (LEA) Services (cont.)	<p><u>Treatment Services</u></p> <ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • 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 language, speech and hearing specialists 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 licensed speech pathologists or licensed audiologists 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. <p>The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed 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.</p>

*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*
23g Local Education Agency (LEA) Services (cont.)		<ul style="list-style-type: none"><li data-bbox="1140 412 1780 472">• Credentialed pupil service workers may provide psychosocial assessments only;<li data-bbox="1140 492 1927 586">• Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only;<li data-bbox="1140 605 1927 781">• 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. <p data-bbox="1140 800 1927 961">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.</p>

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

STATE PLAN CHART

Limitations on Attachment 3.1-B
Page 29

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Personal Care	<p>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.</p>	<p>Personal Care Services shall be available to eligible medically needy aged, blind and disabled individuals 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.</p>

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN No. 02-021
Supercedes
TN No. 94-021

Approval Date JUN 5 2003

Effective Date 1/1/03

STATE PLAN CHART

Limitations on Attachment 3.1-B
Page 30

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Program for All-Inclusive Care for the Elderly (PACE)	<p>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.</p>	<p>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.</p>

**Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN No. 02-003
Supersedes TN No. N/A

Approval Date: SEP 18 2002 Effective Date: JUN - 1 2002