Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

**05-009***

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.

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| Supplement 5 to Attachment 4.19-B, pages 1-4 (TN # 00-015) | Supplement 5 to Attachment 4.19-B, pages 1-9 and Exhibit pages 1-5 |
| Limitations on Attachment 3.1-A, page 2 (TN# 95-014) | Limitations on Attachment 3.1-A, page 2 |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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**STATE PLAN AMENDMENT**
**COST-BASED REIMBURSEMENT**

A. General Applicability

Notwithstanding any other provision of this State Plan, this Supplement 5 sets forth special payment rules that apply to existing categories of services listed below only when those services are provided in clinics and hospital outpatient departments owned and operated by a county containing a population of 4 million and over. This Supplement does not create new medical assistance service categories. This Supplement shall apply only to Medi-Cal services rendered to Medi-Cal beneficiaries on or after July 1, 2005. This Supplement does not apply to those Federally Qualified Health Centers (FQHCs) and FQHC look-alikes paid pursuant to the prospective payment reimbursement provisions set forth in Attachment 4.19-B, page 6 et. seq. of this State plan. This Supplement applies to the following categories of services:

1. Any Medi-Cal covered ambulatory care service provided in hospital outpatient departments owned and operated by a county containing a population of 4 million and over, excluding services provided in hospital emergency departments.

2. Physician and non-physician professional services provided in hospital outpatient departments owned and operated by a county containing a population of 4 million and over (excluding such services when provided in hospital emergency departments). These outpatient professional services provided outside of the emergency department are not reimbursed under the physician fee schedule (page 1 of Attachment 4.19-B) or the provisions for Reimbursement to Specified Government-Operated Providers for Costs of Professional Services (page 52 of Attachment 4.19-B).

3. Any Medi-Cal covered ambulatory care service, which includes professional services provided by physician and non-physician practitioners, provided in freestanding clinics owned and operated by a county containing a population of 4 million and over including, but not limited to, the following types of clinics:

(i) Comprehensive health centers (CHCs).

(ii) Health centers (excluding clinics that provide predominately public health services).

(iii) Multi-specialty ambulatory care centers (MACC).

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For purposes of this Supplement 5, a clinic which provides predominately public health services is defined as a health facility which provides mostly services for the prevention, diagnosis and treatment of diseases which pose a continuing risk, not only to the effected individual, but the public as well, such as tuberculosis and sexually transmitted diseases.

A list of the facilities qualifying and not qualifying for payment under this Supplement 5 as of the approval date is an exhibit hereto. Nothing in this exhibit precludes payment under this Supplement 5 in the future to any listed or unlisted facility which meets the requirements set forth in this Section A.

B. Cost-Based Reimbursement

1. General Methodology. The following general provisions apply to all services identified in section A.

(a) Except as limited in subsection (b) below, reimbursement to eligible facilities shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications (except for modifications described in this Supplement or otherwise approved by the Centers for Medicare & Medicaid Services (CMS)):

(i) The reimbursement methodology for cost-based entities outlined in Title 42 of the Code of Federal Regulations (CFR) Part 413; the Provider Reimbursement Manual (CMS Pub. 15-1); applicable federal directives, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medi-Cal program, except as expressly modified below.

(ii) The allowable costs reimbursed under this methodology include direct, ancillary, physician/non physician practitioner, and overhead costs which are incurred in providing covered services to Medi-Cal beneficiaries in eligible facilities and determined to be allowable under the regulations and publications in Section B.1(a)(i) above.

(iii) In calculating final reimbursement, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this

Supplement 5 shall be used to reduce the amount due from Medi-Cal.

(iv) Each eligible facility will report costs annually on cost reporting forms approved by the Department, which will include a certification that the costs included in the report have been expended. The approved form for the hospital outpatient departments is the CMS 2552 form and supplemental schedules. Physician and non-physician practitioner costs in hospital outpatient departments will also be included, but distinctly identified on these forms. The freestanding clinics which maintain a separate general ledger shall use clinic cost reporting forms that are modeled on the CMS approved FQHC cost reporting form and have been approved by the Department and CMS. The freestanding clinics which share a hospital general ledger shall use the same approved clinic cost reporting forms but derive some of their expenses from the hospitals' CMS 2552. (See Section B.4 below.)

Notwithstanding any regulation to the contrary, cost reports are to be submitted by eligible facilities no later than five (5) months after the close of the fiscal year, unless an extension is granted by the Department.

(v) Annually, the Department will determine interim, all-inclusive payment rates by dividing the total allowable costs from the most recently audited cost reports by total visits from the same reports. All eligible facilities which share the same cost report will be assigned the same interim rate. The State may periodically adjust such rates for inflation or to take into consideration increases or decreases in costs not reflected in the most recently audited cost report to ensure that interim payments approximate actual allowable costs, however, in no event shall interim payments exceed 95% of approximated actual allowable costs.

(vi) Interim payments are made on a per-visit basis throughout the fiscal year, based on the facility's claims.

(vii) The Department will perform an interim reconciliation of interim payments to allowable costs as reported on the filed costs after receipt of the filed cost reports. In performing this interim reconciliation, the Department may, if appropriate, make adjustments to costs reported on the filed cost reports based on the

results of the most recently completed audit of a prior year cost report. Finally, interim payments (as adjusted during the interim reconciliation process) will again be reconciled to actual allowable costs after an audit of the cost report is completed. If, at the end of either the interim reconciliation or audit, it is determined that the eligible facility has been overpaid, the facility shall repay the Medi-Cal program, and the Department shall follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of either the interim reconciliation or audit, it is determined that an eligible facility has been underpaid, the eligible facility will receive an adjusted payment amount.

(viii) Eligible facilities that contract with local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans for care to Medi-Cal enrollees shall not seek supplemental reimbursement under this Supplement for the unmet cost of providing services to such enrollees.

(ix) Eligible facilities that have patients who have coverage under both the Medicare and Medi-Cal programs ("dually eligible patients") shall seek supplemental reimbursement under this Supplement 5 from the State for care to such patients only as follows:

(I) Dually eligible patients treated in the hospital outpatient departments who are entitled to Medi-Cal benefits irrespective of their Medicare coverage shall be treated on the cost report in the same manner as all other Medi-Cal patients, and all Medicare revenue associated with these visits for which there is coverage under both programs shall be deducted from Medi-Cal allowable costs in determining reimbursement.

(II) Dually eligible patients for whom Medi-Cal is responsible only for Medicare cost sharing amounts shall be treated separately for purposes of the cost reports filed under this Supplement 5. Notwithstanding anything else in the Supplement 5, Medi-Cal reimbursement for care to such individuals shall be limited to Medicare cost sharing amounts, or Medi-Cal allowable payment under this Supplement 5 less any payments received by Medicare, whichever is less, in accordance with Supplement 1 to Attachment 4.19-B.

(x) The reasonable compensation equivalent shall be applied to the provider component of physician cost in determining allowable hospital outpatient department expenses.

2. Special rules for physician and non-physician practitioner professional services rendered in hospital outpatient departments (except emergency departments) under this Supplement 5.

(a) Allowable physician and non-physician practitioner professional services provided to Medi-Cal beneficiaries as defined in Section A are payable under this Supplement 5 and are not reimbursable under any other section of this State Plan including the Reimbursement to Specified Government-Operated Providers for Costs of Professional Services supplemental payment provisions (page 52 of Attachment 4.19-B). For purposes of this Supplement 5, non-physician practitioners include:

(i) Certified Nurse Anesthetists

(ii) Physician Assistants

(iii) Nurse Practitioners

(iv) Dentists

(v) Certified Nurse Midwives

(vi) Clinical Social Workers

(vii) Clinical Psychologists

(viii) Optometrists

(b) Costs for physician and non-physician practitioner professional services will be determined consistently with the reimbursement methodology described in SPA 05-023, as set forth below. Allowable professional service costs are those that meet the following requirements:

(i) Are limited to auditable physician and non-physician practitioner compensation expenses incurred by the hospital;

(ii) Relate to the provision of direct patient care;

(iii) Are identified as professional service costs and removed from the hospital's allowable costs on either Worksheet A-8-2 or Worksheet A-8 of the CMS 2552 form;

(iv) Are supported by a time study, accepted by Medicare, that identifies professional direct patient care activities. This requirement shall not apply to temporary physicians who are retained to perform only direct professional patient care activities;

(v) Relate to support staff, data processing or patient accounting for physician or non-physician practitioners and are removed on Worksheet A-8.

(c) Because eligible facilities bill physician and non-physician practitioner professional services using all inclusive rates, itemized physician and non-physician practitioner charges do not exist. Accordingly, physician and non-physician practitioner costs will be apportioned to Medi-Cal by developing a ratio of total allowable physician and non-physician practitioner professional costs to total RVUs for each cost center in which professional services are provided. The RVUs used in this calculation shall be the same as those used on the Medicare or Medi-Cal cost report. This ratio will then be multiplied by the RVUs for Medi-Cal beneficiary services in such cost center to determine Medi-Cal allowable costs. The RVUs used in this process shall be the same as those used to apportion facility service costs.

3. Special rules for hospital outpatient department services under this Supplement 5.

(a) Any expenses reimbursed under the Supplemental Reimbursement for Public Outpatient Hospital Services provisions (page 46 of Attachment 4.19-B) including expenses related to providing services in hospital emergency departments, shall not be reimbursed under this Supplement 5, and any hospital outpatient department expenses reimbursed under this Supplement 5 shall not be reimbursed under the Supplemental Reimbursement for Public Outpatient Hospital Services program (page 46 of Attachment 4.19-B).

(b) The costs of services provided in hospital outpatient departments will be derived from line 60 (and line 60.02 for dental clinic costs if it exists) of the CMS 2552 form and include both direct costs and overhead costs allocated on Worksheets B and B-1. Ancillary costs will be derived from various cost centers on the CMS 2552 form and include both direct and allocated overhead costs from Worksheets B and B-1. Physician and non-physician practitioner costs related to services to the provider, (i.e. identified as allowable provider component of hospital based physician cost on the CMS 2552 form), including the supervision of interns and residents, are included in allowable costs. To apportion the costs, a ratio of total allowable costs to total RVUs is developed for each cost center. The RVUs used in this calculation shall be the same as those used on the Medicare or Medi-Cal cost reports. This ratio is then multiplied by outpatient RVUs for Medi-Cal beneficiaries for each cost center to determine Medi-Cal allowable costs.

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4. Special rules for freestanding clinic services under this Supplement

(a) Freestanding clinics consist of (1) clinics that share a hospital's general ledger ("cluster clinics") and (2) clinics that maintain a separate general ledger ("independent clinics"). The costs of both types of freestanding clinics include direct clinic costs (including the direct expense of providing ancillary services and compensating physicians and non-physician practitioners), clinic overhead costs and if applicable, allocated or assigned hospital overhead expenses.

(b) Cluster clinic costs entered onto the approved clinic cost report are derived from non-reimbursable cost center lines on the CMS 2552 form. Direct service costs and overhead expenses incurred at the cluster clinics are reported on separate CMS cost center lines. Non-allowable costs associated with the cluster clinics are either excluded through adjustments to those cost centers or segregated into separate non-reimbursable cost centers on the CMS 2552 form.

(c) For the independent clinics, allowable costs will be derived from the eligible facility's general ledger, and reported on the approved clinic cost reporting forms. Direct service costs and overhead expenses shall be reported on separate cost center lines, and non-allowable costs will either be reclassified to non-reimbursable cost centers or removed through discrete adjustments. Reclassifications and adjustments to the working trial balance, including the assignment of costs to non-reimburseable cost centers, or and the discrete disallowance of expenses, will be recorded on supporting schedules which will be submitted with the approved cost reporting forms.

(d) General ledger supporting schedules which group costs into the direct service and overhead cost centers will accompany the filed clinic cost reports.

(e) Overhead costs for cluster clinics may include hospital overhead costs either directly reclassified to the freestanding clinics or allocated to them using various statistical bases on the CMS 2552 form. All freestanding clinic overhead will be equitably allocated to non-allowable activities based on the use of such overheard services by the non-allowable activities.

(f) Regardless of the provisions of the regulations and publications at Section B.1(a)(i) above, all freestanding clinic costs will be apportioned to the Medi-Cal program by aggregating all allowable direct and overhead costs and dividing them by total visits for all payors. This ratio is then multiplied by Medi-Cal visits to determine Medi-Cal costs.

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C. Services Eligible for Cost-Based Reimbursement

1. Subject to subsections (2) and (3), below, the services that are subject to cost-based reimbursement in eligible facilities (as defined in Section A, above) include only Medi-Cal-covered ambulatory care services rendered to Medi-Cal beneficiaries, as described in applicable State law and this State Plan. These services include hospital outpatient, hospital physician and non-physician practitioner, and freestanding clinic services. These services are defined in Attachment 3.1-A of the State Plan and include:

Physician and non-physician practitioner
Optometry
Psychology
Podiatry
Physical Therapy
Occupational therapy
Speech Pathology
Respiratory care
Audiology
Acupuncture
Dental
Laboratory and x-ray/imaging services
Blood and Blood derivatives
Chronic hemodialysis
Hearing Aids
Prosthetic and orthotic appliances
Durable medical equipment
Medical supplies
Prescribed drugs
Ambulatory surgery

2. For the purposes of billing Medi-Cal for services reimbursed under this Supplement 5, and for cost reporting under this Supplement 5, a "visit" is defined as a face-to-face encounter between a clinic patient and a health care professional. Multiple visits may be billed to Medi-Cal for services rendered on the same day of service if a clinic Medi-Cal patient receives services from both a medical provider and a provider of dental/oral surgical care (e.g., multiple medical and a dental visit on the same day would be billed as two visits). Multiple visits occurring on the same day for patients with all payor classifications will be counted for cost reporting purposes consistently with the Medi-Cal billing rule described above. Nothing in this section shall restrict the way facilities bill payers other than Medi-Cal for a visit.

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3. Eligible facilities may bill one visit per group education session for each education session that meets Medi-Cal requirements for coverage and one or more eligible Medi-Cal beneficiaries attend. Facilities will bill for only one visit per group education session regardless of the number of Medi-Cal eligible participants in the session. Adjustments to the apportionment statistics will be made to assure the equitable apportionment of the costs of group education sessions to Medi-Cal.

4. The following services are not subject to cost-based reimbursement under this Supplement nor may a visit be counted as a Medi-Cal visit under this Supplement 5:

(a) Medi-Cal specialty mental health services, including Medi-Cal Short Doyle services, under the State's consolidated Section 1915(b) waiver.

(b) Medi-Cal alcohol and drug program services paid through the State Department of Alcohol and Drug Programs.

(c) Adult Day Health Care services.

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## LIST OF NON-QUALIFYING FACILITIES

| Non-Eligible - Predominately Public Health | |
|---|---|
| **Glendale Health Center**<br>(ZZW16076F)<br>501 North Glendale Avenue<br>Glendale, CA 912016 | **Hollywood/Wilshire Health Center**<br>(ZZW16010F)<br>5205 Melrose Avenue<br>Los Angeles, CA 90038 |
| **Pacoima Health Center**<br>(ZZW16072F)<br>13300 Van Nuys Boulevard<br>Pacoima, CA 91331 | **Burke/Simms/Mann Health Center**<br>(ZZW16042F)<br>2509 Pico Boulevard<br>Santa Monica, CA 90405 |
| **North Hollywood Health Center**<br>(ZZW16070F)<br>5300 Tujunga Ave<br>North Hollywood, CA. 91601 | **South Health Center**<br>(ZZW16058F)<br>1522 East 102nd Street<br>Los Angeles, CA 90002 |
| **Monrovia Health Center**<br>(ZZW16102F)<br>330 West Maple Avenue<br>Monrovia, CA 91016 | **Ruth Temple Health Center**<br>(ZZW16014F)<br>3834 South Western Avenue<br>Los Angeles, CA 90062 |
| **Pomona Health Center**<br>(ZZW16108F)<br>750 South Park Avenue<br>Pomona, CA 91766 | **Whittier Health Center**<br>(ZZW16112F)<br>7643 South Painter Avenue<br>Whittier, CA 90602 |
| **Central Health Center**<br>(ZZW16000F)<br>241 North Figueroa Street<br>Los Angeles, CA 90012 | **Torrance Health Center**<br>(ZZW16036F)<br>2300 West Carson Street<br>Torrance, CA 90501 |
| **Central Satellite Clinic**<br>(ZZW16000F)<br>515 E. 6th Street<br>Los Angeles, CA 90013 | **Curtis Tucker Health Center**<br>(ZZW16028F)<br>123 West Manchester Blvd.<br>Inglewood, CA 90301 |
| **Non-Eligible - Alcohol and Drug Services** | |
| **Antelope Valley Rehabilitation Center**<br>(6767)<br>30500 Arrastre Canyon Rd.<br>Acton, CA 93510 | |

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## LIST OF QUALIFYING FACILITIES

| BUDGET UNIT | HOSPITAL OUTPATIENT DEPARTMENT | FREE-STANDING CLINICS SHARING HOSPITAL'S GENERAL LEDGER | OTHER FREE-STANDING CLINICS NOT SHARING HOSPITAL'S GENERAL LEDGER |
|---|---|---|---|
| NORTHEAST CLUSTER | **LAC+USC MEDICAL CENTER** (FHC60373F) including outpatient departments at these locations:<br>**General Hospital**<br>1200 North State Street<br>Los Angeles, California 90033<br>**Outpatient Building**<br>2010 Zonal Avenue<br>Los Angeles, CA 90033<br>**Women's & Childrens Hospital**<br>1240 North Mission Road<br>Los Angeles, California 90033<br>**Rand Schrader Clinic**<br>1300 North Mission Road<br>Los Angeles, California 90033<br>**Maternal/Child AIDS Clinic**<br>1640 Maraengo Street<br>Los Angeles, CA 90033 | **El Monte Comprehensive Health Center**<br>(FHC 16124F)<br>10953 Ramona Blvd.<br>El Monte, California 91731<br>**H. Claude Hudson Comprehensive Health Center**<br>(FHC41124F)<br>2829 South Grand Avenue<br>Los Angeles, California 90007<br>**Edward R. Roybal Comprehensive Health Center**<br>(FHC41126F)<br>245 South Fetterly Avenue<br>Los Angeles, California 90022<br>**La Puente Health Center**<br>(FHC16100F)<br>15930 Central Avenue<br>La Puente, California 91744 | N/A |
| COASTAL CLUSTER | **Harbor/UCLA Medical Center** (FHC40376F) including outpatient departments at these locations:<br>**Harbor/UCLA Outpatient Department**<br>1000 West Carson Street<br>Torrance, California 90509 | **Long Beach Comprehensive Health Center**<br>(FHC00002F)<br>1333 Chestnut Avenue<br>Long Beach, California 90813 | N/A |

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|---|---|---|---|
| | **Harbor-UCLA Family Medicine Clinic**<br>14003 W. Lomita Blvd.<br>Harbor City, California 90710 | **Bellflower Health Center**<br>(FHC16016F)<br>10005 East Flower St.<br>Bellflower, California 90706<br><br>**Wilmington Health Center**<br>(FHC16026F)<br>1325 Broad Avenue<br>Wilmington, California 90744 | |
| **SOUTHWEST CLUSTER** | **PRIOR TO 08/15/2007**<br>**MLK/Harbor Hospital (closed August 15, 2007)***<br>(formerly Martin Luther King, Jr./Drew Medical Center)<br>(FHC40578F)<br>12021 Wilmington Avenue<br>Los Angeles, California 90059<br>* Under the County/State/CMS Extension Agreement for MLK-Harbor Hospital, the County could not submit claims for non-emergency services renderd to Medicare, Medi-Cal, and uninusured patients from May 1, 2007 until August 15, 2007. On August 10, 2007, the Division of Survey and Certification informed MLK-Harbor that it was not in compliance with a number of Medicare Conditions of Participation. Pursuant to the Extension Agreement, the Medicare provider agreement was terminated effective August 15, 2007. | **FYs 2005-06 & 2006-07**<br>**Hubert H. Humphrey Comprehensive Health Center**<br>(FHC11866F)<br>5850 South Main Street<br>Los Angeles, California 90003<br><br>**Dollarhide Health Center**<br>(FHC70077F)<br>1108 North Oleander Street<br>Compton, Calfironia 90221 | **FY 2007-08 & AFTER**<br>**Hubert H. Humphrey Comprehensive Health Center****<br>(FHC11866F)<br>5850 South Main Street<br>Los Angeles, California 90003<br><br>**Dollarhide Health Center****<br>(FHC70077F)<br>1108 North Oleander Street<br>Compton, Calfironia 90221<br>**Due to the closure of MLK-Harbor Hospital on August 15, 2007, these free-standing clinics will not be on the hospital's general ledger. They will be maintained in their own general ledger.<br><br>**Martin Luther King Multi-service Ambulatory Care**<br>**Center (MLK MACC)*****<br>(FHC# pending)<br>12021 Wilmington Avenue<br>Los Angeles, California 90059<br>*** Opened on August 24, 2007 afater the closure of MLK/Harbor Hospital. MLK MACC is located in the same location as the previous hospital. It will be on the same general ledger as Humphrey and Dollarhide. |

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| | | | |
|---|---|---|---|
| RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER | **Rancho Los Amigost National Rehabilitation Center**<br>(FHC42014F)<br>7601 East Imperial Highway<br>Downey, California 90242 | N/A | N/A |
| SAN FERNANDO VALLEY CLUSTER | **Olive View/UCLA Medical Center**<br>(FHC40040G)<br>14445 Olive View Drive<br>Sylmar, California 91342 | **Mid-Valley Comprehensive Health Center**<br>(FHC16088F)<br>7515 Van Nuys Blvd.<br>Van Nuys, California 91405<br><br>**San Fernando Health Center**<br>(FHC16080F, includes Vaughn School Based Clinic)<br>1212 Pico Street<br>San Fernando, California 91340<br><br>**High Desert Health System Multi-service Ambulatory Care Center (HDH MACC)**<br>(FHC70994F)<br>44900 No. 60th St. West<br>Lancaster, CA 93536<br><br>**Antelope Valley Health Center**<br>(FHC16082F)<br>335 East Avenue K-6, Suite B<br>Lancaster, California 93535<br><br>**Lake Los Angeles Comm Clinic**<br>(FHC16012F)<br>16921 East Avenue O, Space G<br>Lake Los Angeles, CA 93591 | N/A |

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|---|---|---|---|
| | | **Littlerock Community Clinic**<br>(FHC70888F)<br>8201 Pearblossom Highway<br>Littlerock, California 93543<br><br>**South Valley Health Center** (formerly Palmdale Health Clinic)<br>(FHC16040F)<br>38350 40th Street East, Suite 100<br>Palmdale, California 93550 | |
| **JUVENILE COURT HEALTH SERVICES** | **N/A** | **N/A** | **Barry J. Nidorf Juvenile Hall** (formerly San Fernando Valley Juvenile Hall)<br>(FHC00003F)<br>16350 Filbert Street<br>Sylmar, CA 93534<br><br>**Central Juvenile Hall**<br>(FHC16008F<br>1605 Eastlake Ave.<br>Los Anheles, CA 90033<br><br>**Dorothy Kirby Center**<br>(FHC16038F)<br>1500 S. Mc Donnell Ave.<br>Los Angeles, CA 90022<br><br>**Los Padrinos Juvenile Hall**<br>(FHC16004F)<br>7285 Quill Drive<br>Downey, CA 90242 |

(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 | The following services are covered:<br>1. Physician<br>2. Optometric<br>3. Psychology<br>4. Podiatric<br>5. Physical therapy<br>6. Occupational therapy<br>7. Speech pathology<br>8. Audiology<br>9. Acupuncture<br>10. Laboratory and X-ray<br>11. Blood and blood derivatives<br>12. Chronic hemodialysis<br>13. Hearing aids<br>14. Prosthetic and orthotic appliances<br>15. Durable medical equipment<br>16. Medical supplies<br>17. Prescribed drugs<br>18. Use of hospital facilities for physicians' services<br>19. Family planning<br>20. Adult day health care<br>21. Respiratory care<br>22. Ambulatory surgery<br>23. Dental | 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 $O_2$ therapy, psoriasis day care, pheresis, and cardiac catheterization.<br><br>Prior authorization is required for psychiatry 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 labels. Routine podiatry office visits are allowed without prior authorization. All other podiatry services are subject to prior authorization.<br><br>Prior authorization is required when the purchase price of durable medical equipment or prosthetic/orthotic appliances exceeds $100.<br><br>Prior authorization is required when cummulative rental or repairs exceed $25. |

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.