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

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

(Note: This chart is an overview only) Limitations on Attachment 3.1-A

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

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

(Note: This chart is an overview only) Limitations on Attachment 3.1-A

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

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

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

* Prior authorization is not required for emergency service.

**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
2a Hospital outpatient department services and community hospital outpatient clinic.		All services, including physician's services, are subject to the same requirements as when provided in a non-facility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program of the SD/MC system.
2b Rural Health Clinic services and other ambulatory services covered under the state plan.	The following Rural Health Clinic (RHC) services are covered under this state plan: 1.Physician services for RHC purposes, physicians are defined as follows: a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license. 1. A primary care resident physician, in a HRSA or State sponsored Teaching Health Center Graduate Medical Education (THCGME) Program, supervised by a designated teaching physician. b. A doctor of podiatry authorized to practice podiatric medicine by the State who is acting within the scope of his/her license c. A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license d. A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license.	Rural health clinics do not require Treatment Authorization Request (TAR) before rendering services; however, RHCs must provide documentation in the medical record that the service was medically necessary. A teaching physician (TP) is identified by the sponsored THCGME Program, which is administered by the Health Resources and Services Administration (HRSA) or State sponsored THCGME Program. The TP may not supervise more than 4 primary care residents at a time. The THCGME Program is required to be accredited by the American Council of Graduate Medical Education.

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

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

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2b. Rural Health Clinic (RHC) services and other ambulatory services covered under the State Plan (continued)	9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license. 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license. 11. Associate Marriage and Family Therapist (AMFT) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Clinical Psychologist, or a Licensed Physician and Surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. 12. Associate Clinical Social Worker (ASW) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology. 13. Licensed Professional Clinical Counselor (LPCC) who is authorized to provide professional clinical counseling services by the State and who is acting within the scope of their license. 14. Associate Professional Clinical Counselor (APCC) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, or a Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology.	a) An AMFT, ASW, APCC supervisor is identified by the Board of Behavioral Science (BBS) requirements. b) The AMFT, ASW, APCC supervisor is a qualified licensed practitioner and must comply with supervision requirements established by the BBS.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2b. Rural Health Clinic (RHC) services and other ambulatory services covered under the State Plan (continued)	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan. (Continued)	Effective January 1, 2018 dental benefits are covered services under this state plan as medically necessary when prescribed by a doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license. Additional services may be covered when medically necessary for pregnant individuals or individuals under age 21 who are eligible for benefits under the Early and Periodic Screening, Diagnostic, and Treatment Program. Rural Health Center home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan.	The following FQHC services are covered under this state plan: 1. Physician services For FQHC purposes, physicians are defined as follows: a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license 1. A primary care resident physician, in a HRSA or State sponsored Teaching Health Center Graduate Medical Education (THCGME) Program, supervised by a designated teaching physician. b. A doctor of podiatry authorized to practice pediatric medicine by the State and who is acting within the scope of his/her license. c. A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license. d. A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license. e. A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license. 2. Physician Assistant (PA) who is authorized to practice PA services by the State and who is acting within the scope of his/her license. 3. Nurse Practitioner (NP) who is authorized to practice NP services by the State and who is acting within the scope of his/her license.	FQHC do not require Treatment Authorization Request (TAR) before rendering services; however, FQHC must provide documentation in the medical record that the service was medically necessary A teaching physician (TP) is identified by the sponsored THCGME Program, which is administered by the Health Resources and Services Administration (HRSA) or State sponsored THCGME Program. The TP may not supervise more than 4 primary care residents at a time. The THCGME Program is required to be accredited by the American Council of Graduate Medical Education.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license. 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license. 6. Comprehensive Perinatal Services Program (CPSP) practitioner services. 7. Licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license. 8. Clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license. 9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license. 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license.	

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the State Plan (continued)	11. Associate Marriage and Family Therapist (AMFT) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Clinical Psychologist, or a Licensed Physician and Surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. 12. Associate Clinical Social Worker (ACSW) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology. 13. Licensed Professional Clinical Counselor (LPCC) who is authorized to provide professional clinical counseling services by the State and who is acting within the scope of their license.	a) An AMFT and ASW supervisor is identified by the Board of Behavioral Science (BBS) requirements. b) The AMFT and ASW supervisor is a qualified, licensed practitioner and must comply with supervision requirements established by the BBS.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2c. and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the State Plan (continued)	14. Associate Professional Clinical Counselor (APCC) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, or a Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology.	a) An APCC supervisor is identified by the Board of Behavioral Science (BBS) requirements. b) The APCC supervisor is a qualified, licensed practitioner and must comply with supervision requirements established by the BBS.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
	FQHC home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3. Other laboratory and X-ray 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 Medi-Cal eligibility (crossover cases), authorization is required at the time of Medicare denial or on or before the 20th day after admission.

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

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPMU 88-17

Eff 7-1-88

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(Note: T 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.

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(Note: ... s chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #1558 17

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(Note: chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #88-17

EFF 7-1-88

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

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

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

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

4. Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (b)(2)(A) through (E) above;

Medical necessity shall be further substantiated by all of the following conditions:

1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the patient's health care needs, and not be any less than the nursing staff ratios specified in Section 51215.8 (g) and (i);

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	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.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4b Early and periodic screening, diagnostic, and treatment (EPSDT) services	Covered for an eligible Medi-Cal beneficiary under age 21. Includes, at a minimum, a broad range of preventive services including “A” or “B” services recommended by the United States Preventive Services Task Force (USPSTF); Advisory Committee on Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants and children recommended by Health Resources and Services Administration’s (HRSA) Bright Futures program/project; and additional preventive services for women as recommended by the Institute of Medicine (IOM). Screening services may also be provided on an interperiodic basis based on medical necessity. The State ensures EPSDT services comply with requirements in 1905(r) of the Social Security Act.	Prior authorization is not required.

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b Early and periodic screening, diagnostic, and treatment (EPSDT) services	All medically necessary services coverable under 1905(a) of the Social Security Act are provided to EPSDT-eligible population individuals. EPSDT covered services are provided to Medicaid eligibles under 21 years of age. Includes rehabilitative mental health services: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day treatment intensive, day rehabilitation offered in local and mental health clinics or in the community, as described in Attachment 3.1-A, Item 13.	Prior authorization is not required.
Services provided by Local Education Agency (LEA) providers	Includes LEA Medi-Cal Billing Option Program services (LEA services). An LEA is the governing body of any school district or community college district, county office of education, charter school, state special school, California State University campus, or University of California Campus. LEA eligible beneficiaries are individuals under age 22 who are Medicaid eligible beneficiaries, regardless of whether the beneficiary has an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA). Any person who becomes 22 years of age while participating in an IEP or IFSP may continue his or her participation in the program for the remainder of that current school year. Freedom of Choice 42 Code of Federal Regulations (CFR) 431.51. The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. LEAs providing LEA services may be subject to on-site review and/or audit by the Center for Medicare and Medicaid Services and/or agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.	LEA services are limited to services provided to eligible Medicaid beneficiaries under an IEP or IFSP under the IDEA, or under an Individualized Health and Support Plan (IHSP).

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Assessment Services** Health and mental health evaluation and education (Early Periodic Screening Diagnostic Treatment (EPSDT), also covered in Items 4b and 13d). EPSDT services are defined as medically necessary when used to correct or ameliorate defects and physical and mental illness and conditions discovered during a regular (periodic) or inter-periodic screening. Health and mental health evaluation and education includes parts of EPSDT assessment and screenings such as: • Developmental Assessment • Health Education and Anticipatory Guidance appropriate to age and health status which includes wellness counseling • Hearing Assessment • Nutritional Assessment • Psychosocial Status Assessment • Vision Assessment LEA covered services also include the following assessment services: • Audiological Assessment • Health Assessment • Occupational Therapy Assessment • Orientation and Mobility Assessment • Physical Therapy Assessment • Psychological Assessment • Respiratory Assessment • Speech-Language Assessment	Practitioner Qualifications and Limitations LEA assessments and treatment services must be performed by practitioners who meet the applicable qualification requirements as defined in 42 CFR Part 440, who render services within their scope of practice, as defined in State law. Authorization for EPSDT screening services will be based on the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care (Periodicity Schedule). In addition, health screenings required for all students by California Education Code or Health and Safety Code will be reimbursable at required intervals.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Treatment Services** LEA covered services include the following services: • Nursing Services (as defined in 42 CFR § 440.166 and § 440.60(a)); ○ School Health Aide Services • Nutrition Services (as defined in 42 CFR § 440.60(a)); • Occupational Therapy Services (as defined in 42 CFR § 440.110(b)(1)); • Optometry Services (as defined in 42 CFR § 440.60(a)); • Orientation and Mobility Services (as defined in 42 CFR § 440.130(d)); • Physical Therapy Services (as defined in 42 CFR § 440.110 (a)(1)); • Physician Services (as defined in 42 CFR § 440.50(a)); • Psychology and Counseling Services (as defined in 42 CFR § 440.50(a) and § 440.130(d)); • Respiratory Care Services (as defined in 42 CFR § 440.60(a)); • Speech-Language and Audiology Services (as defined in 42 CFR § 440.110(c)) Other LEA covered services include the following services: • Specialized Medical Transportation Services (as defined in 42 CFR § 440.170 (a)(1)); • Targeted Case Management (TCM) Services (as defined in Supplement 1c to Attachment 3.1-A.)	

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Nursing Services** Definition: Per 42 CFR § 440.166 and § 440.60 (a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care or services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." <u>Qualified Practitioner Types:</u> • Certified Nurse Practitioners • Certified Public Health Nurses • Licensed Registered Nurses • Licensed Vocational Nurses • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Public Health Nurses must be licensed and certified by the California Board of Registered Nursing. • Registered Nurses must be licensed to practice by the California Board of Registered Nursing. • Vocational Nurses must be licensed to practice by the California Board of Vocational Nursing and Psychiatric Technicians and require supervision by a Licensed Physician, Registered Credentialed School Nurse or Certified Public Health Nurses, when providing specialized physical health care. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**I. School Health Aide Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." School health aide services include support furnished to an individual to assist in medically-necessary health-related functions and Activities of Daily Living (ADLs) related to a beneficiary's physical or mental health limitation due to a disability or health condition. Services and support include, but are not limited to: • Specialized physical health care services, such as catheterization, gastric tube feeding, suctioning, oxygen administration and nebulizer treatments; • Hands on assistance with ADL tasks, such as eating, toileting, transferring, positioning and mobility assistance; • Cueing, such as directing the completion of an ADL task; • Observation, intervening and redirecting to assist with completion of an ADL task. Qualified Practitioner Types: • Trained Health Care Aides	Practitioner qualifications, limits and supervision requirements: • Trained Health Care Aides delivering specialized physical health care services must be trained in the administration of specialized physical health care. Trained Health Care Aides may render LEA services only if supervised by a Licensed Physician or Surgeon, a Registered Credentialed School Nurse or a Certified Public Health Nurse. The State's Scope of Practice Act relating to the licensed profession, and the regulations adopted pursuant to those practice acts, assure that the licensed practitioners assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Nutrition Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." <u>Qualified Practitioner Types:</u> • Certified Nurse Practitioners • Certified Public Health Nurses • Licensed Physicians • Licensed Physician Assistants • Licensed Psychiatrists • Licensed Registered Nurses • Registered Credentialed School Nurses • Registered Dietitians	<u>Practitioner qualifications, limits and supervision requirements:</u> • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Public Health Nurses must be licensed and certified by the California Board of Registered Nursing. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Psychiatrists must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Registered Nurses must be licensed to practice by the California Board of Registered Nursing. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential. • Dietitians must be registered through the Commission on Dietetic Registration. Registered Dietitians and Nutritionists may only provide nutritional assessments and nutritional counseling services.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Occupational Therapy Services** Definition: Per 42 CFR § 440.110(b)(1), occupational therapy services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting by or under the direction of a qualified occupational therapist. It includes necessary supplies and equipment. <u>Qualified Practitioner Types:</u> • Licensed Occupational Therapists • Occupational Therapy Assistants	<u>Practitioner qualifications, limits and supervision requirements:</u> • Occupational Therapists must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Board of Occupational Therapy. • Occupational Therapy Assistants must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Board of Occupational Therapy and require supervision by a Licensed Occupational Therapist.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Types of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Optometry Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." <u>Qualified Practitioner Types:</u> • Certified Nurse Practitioners • Licensed Optometrists • Licensed Physicians • Licensed Physician Assistants • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Optometrists must be licensed by the California Board of Optometry and must have a services credential with a specialization in health. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Orientation and Mobility Services** Definition: Per 42 CFR § 440.130(d), orientation and mobility services are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. Orientation and mobility services include assessment and treatment services to correct or alleviate movement deficiencies created by a loss or lack of vision, but are not limited to: • Motor Development • Residual vision stimulation/training • Sensory development • Street crossing Qualified Practitioner Types: • Orientation and Mobility Specialists	Practitioner qualifications, limits and supervision requirements: • Orientation and Mobility Specialists must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) and possess a Clinical or Rehabilitative Services Credential in Orientation and Mobility.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Physical Therapy Services** Definition: Per 42 CFR § 440.110(a)(1), physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. <u>Qualified Practitioner Types:</u> • Licensed Physical Therapists • Physical Therapist Assistants	<u>Practitioner qualifications, limits and supervision requirements:</u> • Physical Therapists must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Physical Therapy Board. • Physical Therapist Assistants must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Physical Therapy Board and require supervision by a Licensed Physical Therapist.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Physician Services** Definition: Per 42 CFR § 440.50(a), physicians' services, whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician (1) Within the scope of practice of medicine or osteopathy as defined by State law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Qualified Practitioner Types: • Licensed Physicians • Licensed Physician Assistants	Practitioner qualifications, limits and supervision requirements: • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Psychology and Counseling Services** Definition: Per 42 CFR § 440.50(a) and § 440.130(d), psychological and counseling services are recommended by a physician or other licensed practitioner of the healing arts within their scope of his or her practice under state law and provided in an individual or group setting. <u>Qualified Practitioner Types:</u> • Associate Marriage and Family Therapist • Credentialed School Counselors • Credentialed School Psychologists • Credentialed School Social Workers • Licensed Clinical Social Workers • Licensed Educational Psychologists • Licensed Marriage and Family Therapists • Licensed Physicians • Licensed Physician Assistants • Licensed Psychiatrists • Licensed Psychologists • Registered Associate Clinical Social Workers • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • Associate Marriage and Family Therapists must be registered with the California Board of Behavioral Sciences and require supervision by a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Psychologist, or a Licensed Physician and Surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. • Credentialed School Counselors must have a valid pupil personnel services credential with a specialization in school counseling. • Credentialed School Psychologists must have a pupil personnel services credential with a specialization in school psychology. • Credentialed School Social Workers must have a pupil personal services credential with a specialization in school social work. • Clinical Social Workers must be licensed to practice by the California Board of Behavioral Sciences and hold a valid pupil personnel services (PPS) credential issued by the Commission on Teacher Credentialing (CTC), with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Educational Psychologists must be licensed to practice by the California Board of Behavioral Sciences and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS credential holder.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Psychology and Counseling Services (cont.)**	Practitioner qualifications, limits and supervision requirements: • Marriage and Family Therapists must be licensed to practice by the California Board of Behavioral Sciences and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Psychiatrists must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Psychologists must be licensed to practice by the California Board of Psychology and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Associate Clinical Social Workers must be registered with the California Board of Behavioral Sciences and require supervision by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Clinical Psychologist, Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology. • Registered Credentialed School nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Respiratory Care Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." Respiratory care services include, but are not limited to the assessment and therapeutic use of the following: • Oxygen therapy • Humidity therapy • Aerosol therapy • Air clearance techniques • Respiratory assist device • Chest physiotherapy • Assessment of patient's cardiopulmonary status Qualified Practitioner Type: • Licensed Respiratory Care Practitioners	Practitioner qualifications, limits and supervision requirements: • Respiratory Care Practitioners must be licensed by the Respiratory Care Board of California.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Speech-Language and Audiology Services** Definition: Per 42 CFR § 440.110(c), services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting. It includes any necessary supplies and equipment. Qualified Practitioner Type: • Credentialed Audiologists • Credentialed Speech-Language Pathologists • Licensed Audiologists • Licensed Physicians • Licensed Physician Assistants • Licensed Speech-Language Pathologists • Registered School Audiometrists • Speech-Language Pathology Assistants The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR § 440.110.	Practitioner qualifications, limits, and supervision requirements: • Credentialed Audiologists must have a clinical or rehabilitative services credential with an authorization in audiology. • Credentialed Speech-Language Pathologists who have a preliminary or professional clear services credential in speech-language pathology may provide assessments and treatment services related to speech, voice, language, or swallowing disorders. Credentialed Speech-Language Pathologists who do not have a preliminary or professional clear services credential in speech-language pathology may provide services under the direction of a Licensed Speech-Language Pathologist or a Credentialed Speech-Language Pathologist who has a professional clear services credential in speech-language pathology. • Licensed Audiologists must be licensed to practice by the California Speech-Language Pathology and Audiology Board. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Licensed Speech-Language Pathologists must be licensed by the California Speech-Language Pathology and Audiology Board. • Registered School Audiometrists must have a valid certificate of registration issued by the Department of Health Care Services. • Speech-Language Pathology Assistants must register with the Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board and require supervision by a Licensed Speech-Language Pathologist or a Credentialed Speech-Language Pathologist.

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Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.)	**Specialized Medical Transportation Services** Definition: Per 42 CFR § 440.170(a)(1), "transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary. This service is limited to transportation of an eligible child to health related services as listed in a recipient's IEP/IFSP.	Service Limitations and requirements: • Specialized transportation services are available to Medicaid eligible beneficiaries for whom the transportation services are medically necessary and documented in an IEP/IFSP. • Services must be provided on the same date of service that a Medicaid covered service, required by the student's IEP/IFSP, is received. Both the transportation and the covered services must be authorized in the student's IEP/IFSP. • Transportation must be provided on a specially adapted vehicle to and/or from the location where the Medicaid service is received, and includes specialized transportation services that are provided in a litter van, wheelchair van, or a specially adapted vehicle equipped with adaptations, such as: lifts, ramps, and/or restraints driven by employees or contracted by the LEA.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) Services provided by LEA providers (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Targeted Case Management (TCM) Services** Definition: As defined in Supplement 1c to Attachment 3.1-A. Qualified Practitioner Type: • Associate Marriage and Family Therapists • Certified Nurse Practitioners • Certified Public Health Nurses • Credentialed School Counselors • Credentialed School Psychologists • Credentialed School Social Workers • Credentialed Speech-Language Pathologists • Licensed Clinical Social Workers • Licensed Educational Psychologists • Licensed Marriage and Family Therapists • Licensed Occupational Therapists • Licensed Physical Therapists • Licensed Psychologists • Licensed Registered Nurses • Licensed Speech-Language Pathologist • Licensed Vocational Nurses • Program Specialists • Registered Associate Clinical Social Workers • Registered Credentialed School Nurses	Practitioner qualifications, limits and supervision requirements: • A Registered Nurse, or a Public Health Nurse with a license in active status to practice as a registered nurse in California; individual shall have met the educational and clinical experience requirements as defined by the California Board of Registered Nursing, or • An individual with at least a Bachelor's degree from an accredited college or university, who has completed a LEA agency- approved case management training course, or • An individual with at least an Associate of Arts degree from an accredited college, who has completed a LEA agency-approved case management training course and has two years of experience performing case management duties in the health or human services field, or • An individual who has completed a LEA agency-approved case management training course and has four years of experience performing case management duties in a health or human services field.

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

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Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) IDP (cont.)	Physical therapy services provided in accordance with Item 11a. Occupational therapy services provided in accordance with Item 11b. Speech therapy services provided in accordance with Item 11c.	Services must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.110, licensed and within their scope of practice under state law.
	Vision services provided in accordance with Item 5a.	Service must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.50, licensed and within their scope of practice under state law.
	Psychology services provided in accordance with Item 6d.1.	Services must be performed by providers who meet the applicable qualification requirements as defined in 42 CFR Section 440.60, licensed and within their scope of practice under state law.
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) IDP (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	Developmental Therapy is a service that includes activities that increase the parent's/caregiver's recognition and response to the child's verbal and/or non-verbal communication; increase the parent's/caregiver's interpersonal relationship with the child through everyday activities; training and consultation with the parent/caregiver for the direct benefit of the child to demonstrate developmentally appropriate activities for the child's special need to support the acquisition of new skills; and address the achievement of the objectives and outcomes in the child's IFSP. Intervention activities promote development in all of the following areas; gross motor skills; fine motor skills; cognitive development; communication development; social-emotional development; and self-help/adaptive learning. Activities may include, but are not limited to, use of manipulative props and toys, and weights; play and music therapy; role play; responding to the infant/toddler; positive caregiving strategies; and development of routine and ritual. Developmental therapy is provided under the direction of the multidisciplinary IFSP team at the RC, including licensed personnel, to ensure the continuity of the medically necessary services to ameliorate the child's delays and by guiding the therapeutic regimen related to the child's progress. Treatments are recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law.	Developmental therapy may be provided by unlicensed IDP providers, as described on page 9q. Developmental therapy services provided by unlicensed providers are provided in accordance with the preventive benefit (42 CFR 440.130 (c)).

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.)		
4c Family planning services and supplies for individuals of child bearing age.	Covered as physician and pharmaceutical services.	Prior authorization is not required, and informed consent must be obtained in compliance with applicable state law for all sterilizations. Sterilization of persons under 21 years of age is not covered.
5a Physician's Services	As medically necessary, subject to limitations; however, experimental services are not covered.	Physician services do not require prior authorization except as noted below:
*Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.		

STATE PLAN CHART

Type Of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (continued)	**School-Linked Services**	Prior authorization is not required.
School-Linked Services (SLS)	SLS eligible beneficiaries are individuals aged 21 and under who are Medicaid eligible beneficiaries receiving behavioral health services at a school site not pursuant to an individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA). A schoolsite is a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. A school includes a location not owned or operated by a public school or public school district if the school or district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder at that location, including off-campus clinics, mobile counseling units, and similar locations. Freedom of Choice 42 CFR 431.51. The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of 1902(a)(23) of the Social Security Act.	

* Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type Of Service	Program Coverage**	Prior Authorization or Other Requirements*
4b EPSDT (cont.) SLS (cont.)	**Psychology and Counseling Services** Definition: Per 42 CFR § 440.130(d), psychology and counseling services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law and provided in an individual or group setting. Qualified Practitioner Types: • Credentialed School Counselors • Credentialed School Psychologists • Credentialed School Social Workers	Practitioner qualifications, limits and supervision requirements: SLS practitioners shall hold a valid Pupil Personnel Services (PPS) credential issued by the Commission on Teacher Credentialing (CTC), with the appropriate authorization for those services: • Credentialed School Counselors must have a PPS credential with a specialization in school counseling. • Credentialed School Psychologists must have a PPS credential with a specialization in school psychology. • Credentialed School Social Workers must have a PPS credential with a specialization in school social work. SLS Practitioners may furnish services within their scope of their practice under state law and only at a schoolsite, as defined in the state plan.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.) Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered physician services for purposes of program coverage.	Outpatient medical procedures such as hyperbaric 0^2 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.

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

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

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

STATE PLAN CHART

(Note: This chart is an overview only.)

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

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatry	Services by podiatrists are covered benefits when furnished within their scope of practice in accordance with California state law. Routine nail trimming is not covered. Inpatient services are covered only on written order of the physician or podiatrist who admits the patient to the hospital and only when the period of hospital stay is covered by the program.	All services provided in SNFs and ICFs are subject to prior authorization.

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

Routine nail trimming is not covered.

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6c. Chiropractic	Services by chiropractors are covered when furnished within their scope of practice in accordance with California state law. Chiropractic services are limited to manual manipulation of the spine. This is a covered benefit only for the following beneficiaries: 1. Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit. Chiropractic services are covered in Federally Qualified Health Centers and Rural Health Clinics for all beneficiaries.	
	Outpatient chiropractic services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, occupational therapy, and speech therapy.	TAR is required for a chiropractic service visit that exceeds the two-visit limit.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.1 Psychology	Services of the following licensed and unlicensed practitioners may be furnished within their scope of practice in accordance with California state law. The licensed practitioners supervise and assume the professional liability of services furnished by the corresponding unlicensed practitioners. Licensed mental health practictioners • Services of a Licensed Psychologist • Services of a Licensed Clinical Social Worker • Services of a Licensed Marriage and Family Therapist • Services of a Licensed Professional Clinical Counselor Unlicensed mental health practitioners o Services of a Psychological Assistant o Services of an Associate Clinical Social Worker o Services of an Associate Marriage and Family Therapist o Services of an Associate Professional Clinical Counselor	Prior authorization is not required.

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.3 Acupuncture	Services by acupuncturists are covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition when furnished within their scope of practice in accordance with California state law.	
	Outpatient acupuncture services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: audiology, chiropractic, occupational therapy, and speech therapy.	TAR is required for an acupuncture service visit that exceeds the two-visit limit.

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.4	Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR §440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.
6d.5	Licensed Midwife services	All services permitted under scope of practice. Physician supervision is not required.	Services do not require prior authorization.

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

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6 Licensed Registered Dental Hygienists' services	All services permitted under scope of practice of a licensed Registered Dental Hygienists (RDH) as medically necessary, subject to limitations. All licensed RDHs meet Federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6).	A licensed RDH may provide services within the RDH's scope of practice as permitted by their state licensing board which include, but are not limited to, educational services, oral health training programs, oral health screenings, and scaling and root planing services. A licensed RDH is authorized to provide treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; at a sponsored event by a sponsoring entity or at a nonprofit organization; and, • The licensed RDH shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDH's employment upon program enrollment.

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

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6 Licensed Registered Dental Hygienists' services (continued)		All licensed RDHs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDH that are a benefit of the Medi-Cal Dental program and are permitted by the state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). The Medi-Cal Dental Manual of Criteria identifies which services require prior authorization requirements for the above-mentioned services including RDHs. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

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

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7 Licensed Registered Dental Hygienists in Extended Functions' services	All services permitted under scope of practice for a licensed Registered Dental Hygienists in Extended Functions (RDHEFs) as medically necessary, subject to limitations. All licensed RDHEFs meet Federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6).	A licensed RDHEF may provide services within the RDHEF's scope of practice as permitted by their state licensing board which include, but are not limited to, educational services, oral health training programs, oral health screenings, and scaling and root planing services. A licensed RDHEF is authorized to provide treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; and • The licensed RDHEF shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDHEF's employment upon program enrollment.

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**Coverage is limited to medically necessary services.

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7 Licensed Registered Dental Hygienists in Extended Functions' services (continued)		All licensed RDHEFs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHEF that are a benefit of the Medi-Cal Dental program and are permitted by state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). The Medi-Cal Dental Manual of Criteria identifies which services require prior authorization including RDHEFs. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

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

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8 Licensed Registered Dental Hygienists in Alternative Practice's services	All services permitted under scope of practice for a licensed Registered Dental Hygienists in Alternative Practice (RDHAPs) as medically necessary, subject to limitations. All licensed RDHAPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6).	A licensed RDHAP may provide services within the RDHAP's scope of practice as permitted by their state licensing board which include, but are not limited to, educational services, oral health training programs, oral health screenings, and scaling and root planing services. All licensed RDHAPs are authorized to provide treatment performed in the following settings: residences of the homebound, schools, residential facilities and other settings permissible under federal and state law.

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

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8 Licensed Registered Dental Hygienists in Alternative Practice's services (continued)		All licensed RDHAPs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. Upon enrollment, all RDHAPs shall provide documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHAP that are a benefit of the Medi-Cal Dental program and are permitted by state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). Prior authorization is required for Scaling and Root Planing. The Medi-Cal Dental Manual of Criteria identifies which services require prior authorization including RDHAPs. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.9. Licensed Pharmacist Services	Licensed Pharmacist may perform all services under California's Scope of Practice Act law.	Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Limited to medically necessary services only. Does not include dispensing services outlined in Supplement 2 to Attachment 4.19-B Licensed Pharmacist Services are limited to 6 visits in 90 days. Additional encounters may be authorized when determined medically necessary by the state Medication Therapy Management (MTM) Services are provided by a licensed pharmacist to a recipient to optimize the therapeutic outcomes of the recipient's medications and prevent medication-related problems. A pharmacist intern may provide MTM services under the direct supervision of a licensed pharmacist who assumes the professional responsibility for the services of the pharmacist intern. MTM services are limited to any willing pharmacist that agrees to meet the requirements

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.9. Licensed Pharmacist Services (cont.)		of participation for a defined list of covered drug categories. A qualified pharmacist may provide MTM services in person or via telehealth. Telehealth services are subject to the same provision of services that are provided to a recipient in person. Providers must ensure the privacy of the recipient and secure any information shared via telehealth. Services are limited to a total of six encounters per recipient per 365-day period. When the treatment duration of a medication is less than six months, coverage is limited to one encounter per month of treatment. Additional encounters may be authorized when determined medically necessary by the state.

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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7. Home Health Services Home health agency services, including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.	Home health services are covered after a face-to-face encounter with a physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA) or a certified nurse midwife, in accordance with 42 CFR 440.70, when furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician, NP, CNS, or PA as part of a written plan of care that the ordering practitioner reviews every 60 days. Home health services include the following services: 1. Skilled nursing services as provided by a nurse licensed by the state. 2. Physical therapy services as provided by a physical therapist licensed by the stated in accordance with 42 CFR 440.110. 3. Occupational therapy services as provide by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110. 4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110. 5. Home health aide services provided by a Home Health Agency.	

*Prior authorization is not required for emergency services.
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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7a. Home health nursing and 7b. Home health aide services	Medical supplies, equipment, and appliances suitable for use in any setting in which normal activities take place. Services are provided at a participant's residence, which does not include a hospital, nursing facility or ICF/IID. Services must be medically necessary.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. All additional services and evaluations require prior authorization.
7c.1 Medical supplies	As prescribed by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant within the scope of his/her practice. Common household items, supplies not primarily medical in nature, and articles of clothing are not covered. Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable. Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	Prior authorization is required for certain items and for items not used for the conditions specified in the Medical Supplies Formulary.

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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies (cont.)	Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donations cannot be obtained is required from blood banks supplying the blood or facility where transfusion is given.
7c.2 Durable medical equipment	Covered after a face-to-face encounter with a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or a physician assistant (PA) when prescribed by a physician, NP, CNS, or PA and reviewed annually by the prescribing practitioner, in accordance with 42 CFR 440.70. DME commonly used in providing SNF and ICF level of care is not separately billable, Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $250, except that the provision of more than two “H” oxygen tanks in any one month requires prior authorization. Purchase of rental of “By Report” (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3 Hearing aids	Refer to Type of Service “12c Prosthetic and orthotic appliances, and hearing aids.”	Refer to Type of Service “12c Prosthetic and orthotic appliances, and hearing aids.

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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.3 Enteral Formulae	Covered only when supplied by a pharmacy provider as prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable.	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.
	Common household items (food) are not covered.	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.

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

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TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
9. Clinical services (continued)	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
10. Dental services	Effective January 1, 2018, pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, based on medical necessity. For beneficiaries 21 years of age and older, there is an $1,800 annual benefit maximum, unless medically necessary or under the following exceptions: • 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 • Pregnancy-related services and for other conditions that might complicate the pregnancy • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses • Services provided in long-term care facilities For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Ace (42 U.S.C. Sections 1396d(a)(4)(B) and (r)), early and periodic screening, diagnostic, and treatment services are covered. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not covered benefits.	All limitations may be exceeded based on medical necessity and approved through a prior authorization or exemption process.

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

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
10 Dental services (continued)	Effective July 1, 2015, under California law, Medi-Cal enables providers to practice synchronous and asynchronous teledentistry.	

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

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

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11b. Occupational Therapy	Occupational therapy is covered for the restoration, maintenance, and acquisition of skills only when prescribed by a physician, dentist, or podiatrist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Outpatient occupational therapy provided in a certified rehabilitation center is covered only when billed by the rehabilitation center.	Services must be performed by providers who meet the applicable qualification requirements as defined for occupational therapy in 42 CFR Section 440.110(b), licensed and within their scope of practice under state law.
	In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	More than one evaluation visit in a six-month period requires authorization.
	Outpatient occupational therapy services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: acupuncture, audiology, chiropractic, and speech therapy.	TAR is required for an occupational therapy visit that exceeds the two-visit limit.

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**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance, and acquisition of skills and audiology may be provided only upon the prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Speech therapy and audiology provided in a certified rehabilitation center is covered only when billed by the rehabilitation center. In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization. Outpatient speech therapy and audiology services are limited to a maximum of two services in any one calendar month or any combination of two services per month from among the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, chiropractic, and occupational therapy.	Services must be performed by providers who meet the applicable qualification requirements as defined for speech therapy and audiology services in 42 CFR Section 440.110(c), licensed and within their scope of practice under state law. More than one evaluation visit in a six-month period requires authorization. TAR is required for a speech therapy or audiology visit that exceeds the two-visit limit.

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

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

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

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12a	Pharmaceutical services and prescribed drugs	Covered when prescribed by a licensed practitioner. Drugs for the treatment of hospital inpatients are covered as encompassed in the formulary of the hospital. Drugs administered for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are covered, but payable only when included in the all-inclusive rate.	Prior authorization is not required for drugs listed on the Contract Drug List (CDL), except that certain drugs on the CDL are subject to prior authorization unless used as specified therein. Except for hospital inpatients, prescriptions shall not exceed a 100-calendar-day supply. Hospital inpatient drugs, as encompassed in the formulary of the hospital, do not require prior authorization. Hospital discharge medications may not exceed a ten-day supply. Certain drugs on the CDL are subject to minimum or maximum dispensing quantities. Drugs not on the CDL are subject to prior authorization, except that certain drugs are excluded from Medi-Cal program coverage. .

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b.	Dentures	Full or partial dentures once every five-year period. Immediate dentures once in a lifetime.	All limitations may be exceeded based on medical necessity and approved through a prior authorization or exemption process.
12c.	Prosthetic and orthotic appliances, and hearing aids.	Prosthetic and orthotic appliances are covered when prescribed by a physician or other licensed practitioner within their scope of practice. Hearing aids are covered only when supplied by a hearing aid dispenser upon the prescription of an otolaryngologist or the attending physician where there is no otolaryngologist available. Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered. Replacement of hearing aids that are lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control is not included in the $1,510 maximum benefit cap. Hearing aid benefits are subject to a $1,510 maximum cap per beneficiary per fiscal year, although this limit can be exceeded based on medical necessity through prior authorization. Hearing aid benefits include hearing aids and hearing aid supplies and accessories. The following beneficiaries are exempt from the cap: • Pregnant women, if hearing aids are part of their pregnancy related services or for services to treat a condition that might complicate their pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment Program.	Prior authorization is required. Prior authorization is required for the purchase or trial period rental of hearing aids and for hearing aid repairs which exceed a cost of $25. Cords, receivers, ear molds, and hearing aid garments are covered without prior authorization.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the prescription of a physician or optometrist.	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of glasses. Prior authorization is required for ophthalmic lenses and specialty frames that cannot be supplied by the fabricating optical laboratory.
13a. Diagnostic Services	Covered under this state plan only for the EPSDT benefit.	
13b. Screening Services	Covered under this state plan only for the EPSDT benefit.	
13c. Preventive Services	Includes, at a minimum, a broad range of preventive services, including “A” or “B” services recommended by the United States Preventive Services Task Force (USPSTF); approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, as described in section 1905(a)(13)(B) of the Social Security Act; preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration’s Bright Futures program/project; and additional preventive services for women as recommended by the Institute of Medicine (IOM). Services are provided and covered by a physician or other licensed practitioner within the scope of his or her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services. The State assures that the benefit package will be updated as changes are made to USPSTF, ACIP, and IOM recommendations, and that the State will update coverage and billing codes to comply with these revisions.

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

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont.) Behavioral Health Treatment (BHT)	Covered as medically necessary services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of Autism Spectrum Disorder (ASD). In accordance with 42 CFR 440.130(c), Behavioral Health Treatment (BHT) services, such as Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary. Services that treat or address ASD under this state plan are available only for the following beneficiaries: infants, children and adolescents under 21 years of age. Services that treat or address ASD will be provided to all children who meet the medical necessity criteria for receipt of the service(s). Services include: • Behavioral-Analytic Assessment and development of behavioral treatment plan; and • BHT intervention services are identified in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1. BHT intervention-services are interventions designed to treat ASD, including a variety of behavioral interventions identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.	BHT intervention services are provided under a prior authorized behavioral treatment plan that has measurable goals over a specific timeline for the specific patient being treated and is developed by a qualified autism service provider. The behavioral treatment plan shall be reviewed no less than once every six months by a qualified autism service provider. Services identified in the behavioral treatment plan may be modified and must be prior authorized. Additional service authorization must be received to continue the service. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility. Services must be provided, observed and directed under an approved behavioral treatment plan developed by a qualified autism service provider, as described in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1. The behavioral health treatment plan is not used for purposes of providing or coordinating respite, day care, or educational services. No reimbursement is available for respite, day care or educational services. No reimbursement is available to a parent or caregiver of an individual receiving BHT for costs associated with their participation under the treatment plan. BHT services may be provided by one of the following: Qualified Autism Service Provider (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1)

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

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont.) BHT Services (cont.)		Qualified Autism Service Professional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1) Qualified Autism Service Paraprofessional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1)
13c	Diabetes Prevention Program (DPP) Services	DPP services are a set of medically necessary services recommended by a physician or other licensed practitioner of the healing arts to prevent or delay the onset of type 2 diabetes for beneficiaries with indications of prediabetes, in accordance with 42 CFR 440.130(c). DPP services provide a variety of behavioral and nutritional interventions identified as evidence-based by clinical research or studies and/or nationally recognized organizations specializing in disease control and prevention. Medically necessary DPP services are provided during sessions that occur at regular, periodic intervals over the course of one year, and, if eligible based upon individual measurable health-outcomes, additional ongoing maintenance sessions at regular, periodic intervals for another year. At these sessions, DPP services include:	A DPP services provider must be an organization enrolled in Medi-Cal and must have either pending, preliminary, or full recognition by the Centers for Disease Control and Prevention (CDC) for DPP. DPP services providers use lifestyle coaches for delivery of DPP services. DPP services are delivered by lifestyle coaches and must have completed nationally recognized training for delivery of DPP services. Lifestyle coaches may be: • Physicians • Licensed nonphysician practitioners, such as nurses, and physical therapists. • Unlicensed practitioners under the supervision of a DPP services provider or a licensed Medi-Cal practitioner.

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

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c Diabetes Prevention Program (DPP) Services (Cont.)	• Individual or group nutrition or behavioral counseling. • Physical activity and fitness assessments. Comparable services are available to children under age 18, pursuant to EPSDT.	For DPP services delivered by unlicensed lifestyle coaches, the supervising Medi-Cal practitioner will assume professional liability for care of the patient and furnish services within its scope of practice according to state law. All lifestyle coaches must complete at least 12 hours of training in DPP services from an organization recognized by the CDC for DPP. All lifestyle coaches must be trained to the specific curriculum being used by the recognized organization before offering their first class.

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**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c. Community Health Worker Services	Community Health Worker (CHW) services are preventive health services, as defined in 42 CFR 440.130(c), to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and efficiency. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health-related social needs. CHW services may: • Be provided in an individual or group setting. • Address issues that include but are not limited to: control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention. • Include: o Health education to promote the beneficiary's health or address barriers to health care, including providing information or instruction on health topics. The content of health education must be consistent with established or recognized health care standards. Health education may include coaching and goal	Pursuant to 42 CFR Section 440.130(c), CHW services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. CHWs must be supervised by a Medi-Cal-enrolled community-based organization, local health jurisdiction, licensed provider, pharmacy, hospital, or clinic, as defined in 42 CFR 440.90. CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served. CHWs must demonstrate minimum qualifications through one of the following pathways: • **Certificate Pathway**: 1. **CHW Certificate**: A certificate of completion, including but not limited to any certificate issued by the State of California or a State designee, of a curricula that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation,

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**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c. Community Health Worker Services (continued)	setting to improve a beneficiary's health or ability to self-manage health conditions. o Health navigation to provide information, training, referrals, or support to assist beneficiaries to: ▪ Access health care, understand the health care system, or engage in their own care. ▪ Connect to community resources necessary to promote a beneficiary's health, address health care barriers, or address health-related social needs. o Screening and assessment to identify the need for services. o Individual support or advocacy that assists a beneficiary in preventing a health condition, injury, or violence. CHW violence prevention services are evidence-based, trauma-informed, and culturally responsive preventive services to beneficiaries who have been violently injured as a result of community violence. Violence prevention services include all CHW services listed above by an individual who is qualified by any of the three pathways. Enhanced CHW services are tailored preventive services for beneficiaries with significant behavioral health needs, defined as beneficiaries who meet the access criteria for specialty mental health and/or substance use disorder	capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health, as determined by the supervising provider. Certificate programs shall also include field experience as a requirement. 2. **Violence Prevention Certificate:** For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute. A Violence Prevention Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services shall demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate. • **Work Experience Pathway**: An individual who has 2,000 hours working as a CHW in paid or volunteer positions within the

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c. Community Health Worker Services (continued)	services. Enhanced CHW services include all CHW services listed above provided by a qualified CHW. CHW services, including violence prevention services and enhanced CHW services do not include the following: • Clinical case management/care management that requires a license. • Child care • Chore services including shopping and cooking. • Companion services • Employment services • Helping a recipient enroll in government programs or insurance that is not related to improving their health as part of a care plan. • Delivery of medication, medical equipment, or medical supply. • Personal Care services/homemaker services. • Respite care • Services that duplicate another covered Medi-Cal service. • Socialization • Transportation	previous three years, and has demonstrated skills and practical training in the areas described above, as determined by the supervisor, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Medi-Cal beneficiary. All CHWs must complete a minimum of 6 hours of continuing education training annually.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c. Asthma Preventive Services	Covered as medically necessary for asthma preventive services that prevent disease progression, prolong life, and promote physical health. Asthma preventive services include evidence-based asthma self-management education and asthma trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma. Asthma trigger assessment means the identification of common asthma triggers, including allergens and irritants. This assessment will guide the self-management education about actions to mitigate or control exposures to asthma triggers.	Pursuant to 42 CFR 440.130(c), asthma preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Asthma preventive services are limited to two services per year and asthma trigger assessments are limited to two assessments per year, although additional services and assessment may be provided with prior authorization for medical necessity. Unlicensed asthma preventive service providers must be supervised by either a physician; physician assistant; nurse practitioner; clinic; hospital; a Medi-Cal-enrolled local health jurisdiction or community-based organization. Asthma preventive services may be provided by licensed practitioners within their scope of practice and by unlicensed asthma preventive service providers who meet the qualifications listed here. Unlicensed asthma preventive service providers must have completed either of the following: • A certificate from the California Department of Public Health Asthma Management Academy, or • A certificate demonstrating completion of a training program consistent with the

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
		guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma with core competences in the following areas: o Basic facts of asthma's impact on the human body, including asthma control o Roles of medications o Enviornmental control measures o Teaching individuals about asthma self-monitoring o Implementation of a plan of care o Effective communication strategies, including at a minimum, cultural and linguistic competency and motivational interviewing o Roles of a care team and community referrals All unlicensed asthma preventive service providers must also complete both of the following: o A minimum of 16 hours of face-to-face client contact focused on asthma management and prevention. o Four hours annually of continuing education on asthma.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

13c Doula Preventive Services	Doula services encompass the health education; advocacy; and physical, emotional, and nonmedical support provided before, during, and after childbirth or end of a pregnancy, including throughout the postpartum period. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.
	
	Doulas offer various types of support, including perinatal, labor, and miscarriage support and guidance; health navigation; evidence-based education for prenatal, postpartum, childbirth, and newborn/infant care; lactation support; development of a birth plan; and linkages to community-based resources.
		Doula services are provided as preventive services pursuant to 42 CFR Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.
		
		An additional recommendation from a physician or other licensed practitioner of the healing arts is required for more than 11 visits during the perinatal period, excluding labor and delivery and miscarriage support.
		
		All doulas must be at least 18 years old, possess an adult/infant CPR certification, and have completed basic HIPAA training.
		
		In addition, a doula must meet either of the following qualification pathways:
		
		Training Pathway:
		
		• Complete a minimum of 16 hours of training in the following areas:
		  ○ Lactation support
		  ○ Childbirth education
		  ○ Foundations on anatomy of pregnancy and childbirth
		  ○ Nonmedical comfort measures, prenatal support, and labor support techniques
		  ○ Developing a community resource list
		• Provide support at a minimum of three births

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

Experience Pathway:

- Or all of the following:
  - At least 5 years of active doula experience in either a paid or volunteer capacity within previous seven years.
  - Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following:
    - 3 written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula.

Doulas must complete three hours of continuing education in maternal, perinatal, and/or infant care every three years.

* 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.)

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

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

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	See Supplement 3 to Attachment 3.1-A for program coverage and eligibility details.	Services are based on medical necessity.
13.d.5 Substance Use Disorder Treatment Services	Substance use disorder treatment services include:	
	Narcotic treatment program (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Outpatient Treatment Services (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.

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

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Intensive Outpatient Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Perinatal Residential Substance Use Disorder Treatment (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. The cost of room and board are not reimbursable DMC services.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.6 Expanded Substance Use Disorder Treatment Services	Expanded Substance Use Disorder Treatment Services are provided within the following levels of care (see Supplement 3 to Attachment 3.1-A for additional details):	Prior authorization is required for select Expanded Substance Use Disorder Treatment Services (as indicated below):
	1. Outpatient Treatment Services	Prior authorization is not required.
	2. Intensive Outpatient Treatment Services	Prior authorization is not required.
	3. Partial Hospitalization Services	Prior authorization is not required.
	4. Residential Treatment Services	Prior authorization is required.
	5. Narcotic Treatment Program	Prior authorization is not required.
	6. Withdrawal Management Services	Prior authorization is not required.

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

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

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

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

TN No. 00-016
Supercedes TN No. ~~97-005~~ N/A
PJD

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

STATE PLAN CHART

(Note: This chart is an overview only)

Limitations on Attachment 3.1-A

TYPE OF SERVICE		PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15	Nursing facility level A	Covered when patient is under the care of a physician who because of mental or physical conditions or both (above the level of board and care) requires out-of-home protective and supportive care living arrangements with 24-hour supervision and skilled nursing care on an ongoing intermittent basis. The patient must be visited by a physician at least every 60 days.	Prior authorization is required. The patient physician must recertify patient's need for continued care every 60 days.
15a	ICF services for the developmentally disabled (ICF-DD), ICF-DD Habilitative (ICF DD-H), or ICF-DD Nursing (ICF DD-N)	Covered only for developmentally disabled persons who require 24-hour care in a protected setting and who require and will benefit from the services provided. The developmentally disabled nursing services are for those who are more medically fragile.	Prior authorization is required. The patient physician must recertify patient's need for continued care on the same schedule as required for ICFs.
16	Inpatient psychiatric facility services for individuals under 22 years of age	Inpatient psychiatric services in an institution for mental diseases are covered under this state plan for persons under age 21 or in certain circumstances up to the 22 years of age when the inpatient treatment is initiated prior to reaching 21 years of age. See "1 Inpatient Hospital Services."	Prior authorization is required for all non-emergency hospitalizations. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization. Emergency admission requires a statement from a physician or practitioner performing within his or her scope of licensure to support the emergency admission. See "1 Inpatient Hospital Services."

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

(Note: This chart is an overview only)

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1g to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria. Case management, including targeted case management, means services that will assist eligible individuals in gaining access to needed medical, social, educational, and other services. Case management includes all of the following: • Assessment of an eligible individual • Development of a specific care plan • Referral to services • Monitoring activities	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself that do not meet the definition of targeted case management • Direct delivery of underlying medical, social, educational, or other services to which an eligible individual has been referred • Activities that are integral to the administration of foster care programs or most other non-medical program • Services which are an integral part of another service already reimbursed by Medicaid • Restricting or limiting access to services, such as through prior authorization • Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determination or claims processing

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

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

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

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Preventive Services provided in the home, by Comprehensive Perinatal Services Providers, which are clinics and hospital outpatient departments, as medically necessary for pregnancy-related conditions only. Services are covered throughout pregnancy and through the end of the month in which the 60th day period following termination of pregnancy ends.	Prior authorization is required when services are provided in excess of the basic allowances. Basic allowances are described in Title 22, Sections 51348 and 51504.
21	Ambulatory prenatal care to pregnant women provided during a single limited period of presumptive eligibility. The scope of benefits is limited to specified outpatient pregnancy related services and does not include abortion or labor and delivery services.	Prior authorization is not required.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
24a. Transportation services	Nonemergency medical transportation (NEMT) is covered by litter van, wheelchair van, or ambulance when transportation by ordinary means is contraindicated and transportation is required for a covered Medi-Cal benefit, subject to limitations. Nonmedical transportation (NMT), which includes roundtrip transportation by public or private conveyance, is covered, subject to utilization controls and permissible time and distance standards, to obtain covered Medi-Cal services. For more information, please see Attachment 3.1-D.	All NEMT services require prior authorization and a written prescription by a licensed provider. Only the lowest cost type of medical transportation adequate for the patient's needs is covered. Emergency claims must be accompanied by justification.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
24b. Services furnished in Religious Nonmedical Health Care Institutions	Limited to the extent allowed under the Title XVIII of the Social Security Act. Furnishes nonmedical services exclusively by nonmedical personnel. Covered when patient has a need for inpatient services and/or daily special rehabilitation services, which as a practical matter, can only be provided on an inpatient basis.	Services require prior authorization.
24c. Reserved		
24d. SNF services provided for patients under 21 years of age	See 4a	See 4a.
24e. Emergency hospital services	See 1.	See 1.
24f. Reserved		

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services	An LEA is the governing body of any school district or community college district, county office of education, charter school, state special school, California State University campus, or University of California Campus. LEA eligible beneficiaries are individuals under age 22 who are Medicaid eligible beneficiaries, regardless of whether the beneficiary has an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA). Any person who becomes 22 years of age while participating in an IEP or IFSP may continue his or her participation in the program for the remainder of that current school year. Freedom of Choice 42 Code of Federal Regulations (CFR) 431.51. The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. LEAs providing LEA services may be subject to on-site review and/or audit by the Center for Medicare and Medicaid Services and/or agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.	LEA services are limited to services provided to eligible Medicaid beneficiaries under an IEP or IFSP under the IDEA, or under an Individualized Health and Support Plan (IHSP).

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Assessment Services** Health and mental health evaluation and education (Early Periodic Screening Diagnostic Treatment (EPSDT), also covered in Items 4b and 13d). EPSDT services are defined as medically necessary when used to correct or ameliorate defects and physical and mental illness and conditions discovered during a regular (periodic) or inter-periodic screening. Health and mental health evaluation and education includes parts of EPSDT assessment and screenings such as: • Developmental Assessment • Health Education and Anticipatory Guidance appropriate to age and health status which includes wellness counseling • Hearing Assessment • Nutritional Assessment • Psychosocial Status Assessment • Vision Assessment LEA covered services also include the following assessment services: • Audiological Assessment • Health Assessment • Occupational Therapy Assessment • Orientation and Mobility Assessment • Physical Therapy Assessment • Psychological Assessment • Respiratory Assessment • Speech-Language Assessment	Practitioner Qualifications and Limitations LEA assessments and treatment services must be performed by practitioners who meet the applicable qualification requirements as defined in 42 CFR Part 440, who render services within their scope of practice, as defined in State law. Authorization for EPSDT screening services will be based on the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care (Periodicity Schedule). In addition, health screenings required for all students by California Education Code or Health and Safety Code will be reimbursable at required intervals.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Treatment Services** LEA covered services include the following services: • Nursing Services (as defined in 42 CFR § 440.166 and § 440.60(a)); ○ School Health Aide Services • Nutrition Services (as defined in 42 CFR § 440.60(a)); • Occupational Therapy Services (as defined in 42 CFR § 440.110(b)(1)); • Optometry Services (as defined in 42 CFR § 440.60(a)); • Orientation and Mobility Services (as defined in 42 CFR § 440.130(d)); • Physical Therapy Services (as defined in 42 CFR § 440.110 (a)(1)); • Physician Services (as defined in 42 CFR § 440.50(a)); • Psychology and Counseling Services (as defined in 42 CFR § 440.50(a) and § 440.130(d)); • Respiratory Care Services (as defined in 42 CFR § 440.60(a)); • Speech-Language and Audiology Services (as defined in 42 CFR §440.110(c)) Other LEA covered services include the following services: • Specialized Medical Transportation Services (as defined in 42 CFR § 440.170 (a)(1)); • Targeted Case Management (TCM) Services (as defined in Supplement 1c to Attachment 3.1-A.)	

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Nursing Services** Definition: Per 42 CFR § 440.166 and § 440.60 (a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care or services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." <u>Qualified Practitioner Types:</u> • Certified Nurse Practitioners • Certified Public Health Nurses • Licensed Registered Nurses • Licensed Vocational Nurses • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Public Health Nurses must be licensed and certified by the California Board of Registered Nursing. • Registered Nurses must be licensed to practice by the California Board of Registered Nursing. • Vocational Nurses must be licensed to practice by the California Board of Vocational Nursing and Psychiatric Technicians and require supervision by a Licensed Physician, Registered Credentialed School Nurse or Certified Public Health Nurses, when providing specialized physical health care. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**I. School Health Aide Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." School health aide services include support furnished to an individual to assist in medically-necessary health-related functions and Activities of Daily Living (ADLs) related to a beneficiary's physical or mental health limitation due to a disability or health condition. Services and support include, but are not limited to: • Specialized physical health care services, such as catheterization, gastric tube feeding, suctioning, oxygen administration and nebulizer treatments; • Hands on assistance with ADL tasks, such as eating, toileting, transferring, positioning and mobility assistance; • Cueing, such as directing the completion of an ADL task; • Observation, intervening and redirecting to assist with completion of an ADL task. Qualified Practitioner Types: • Trained Health Care Aides	Practitioner qualifications, limits and supervision requirements: • Trained Health Care Aides delivering specialized physical health care services must be trained in the administration of specialized physical health care. Trained Health Care Aides may render LEA services only if supervised by a Licensed Physician or Surgeon, a Registered Credentialed School Nurse or a Certified Public Health Nurse. The State's Scope of Practice Act relating to the licensed profession, and the regulations adopted pursuant to those practice acts, assure that the licensed practitioners assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Nutrition Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." <u>Qualified Practitioner Types:</u> • Certified Nurse Practitioners • Certified Public Health Nurses • Licensed Physicians • Licensed Physician Assistants • Licensed Psychiatrists • Licensed Registered Nurses • Registered Credentialed School Nurses • Registered Dietitians	<u>Practitioner qualifications, limits and supervision requirements:</u> • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Public Health Nurses must be licensed and certified by the California Board of Registered Nursing. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Psychiatrists must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Registered Nurses must be licensed to practice by the California Board of Registered Nursing. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential. • Dietitians must be registered through the Commission on Dietetic Registration. Registered Dietitians and Nutritionists may only provide nutritional assessments and nutritional counseling services.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Occupational Therapy Services** Definition: Per 42 CFR § 440.110(b)(1), occupational therapy services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting by or under the direction of a qualified occupational therapist. It includes necessary supplies and equipment. <u>Qualified Practitioner Types:</u> • Licensed Occupational Therapists • Occupational Therapy Assistants	<u>Practitioner qualifications, limits and supervision requirements:</u> • Occupational Therapists must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Board of Occupational Therapy. • Occupational Therapy Assistants must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Board of Occupational Therapy and require supervision by a Licensed Occupational Therapist.

STATE PLAN CHART

Types of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Optometry Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." Qualified Practitioner Types: • Certified Nurse Practitioners • Licensed Optometrists • Licensed Physicians • Licensed Physician Assistants • Registered Credentialed School Nurses	Practitioner qualifications, limits and supervision requirements: • Nurse Practitioners must be licensed and certified to practice as Nurse Practitioners, whose practices are predominately that of primary care, by the California Board of Registered Nursing. • Optometrists must be licensed by the California Board of Optometry and must have a services credential with a specialization in health. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Orientation and Mobility Services** Definition: Per 42 CFR § 440.130(d), orientation and mobility services are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. Orientation and mobility services include assessment and treatment services to correct or alleviate movement deficiencies created by a loss or lack of vision, but are not limited to: • Motor Development • Residual vision stimulation/training • Sensory development • Street crossing <u>Qualified Practitioner Types:</u> • Orientation and Mobility Specialists	<u>Practitioner qualifications, limits and supervision requirements:</u> • Orientation and Mobility Specialists must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) and possess a Clinical or Rehabilitative Services Credential in Orientation and Mobility.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Physical Therapy Services** Definition: Per 42 CFR § 440.110(a)(1), physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. <u>Qualified Practitioner Types:</u> • Licensed Physical Therapists • Physical Therapist Assistants	<u>Practitioner qualifications, limits and supervision requirements:</u> • Physical Therapists must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Physical Therapy Board. • Physical Therapist Assistants must meet personnel qualifications at 42 CFR § 484.115 and be licensed to practice by the California Physical Therapy Board and require supervision by a Licensed Physical Therapist.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Physician Services** Definition: Per 42 CFR § 440.50(a), physicians' services, whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician (1) Within the scope of practice of medicine or osteopathy as defined by State law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Qualified Practitioner Types: • Licensed Physicians • Licensed Physician Assistants	Practitioner qualifications, limits and supervision requirements: • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Psychology and Counseling Services** Definition: Per 42 CFR § 440.50(a) and § 440.130(d), psychological and counseling services are recommended by a physician or other licensed practitioner of the healing arts within their scope of his or her practice under state law and provided in an individual or group setting. <u>Qualified Practitioner Types:</u> • Associate Marriage and Family Therapist • Credentialed School Counselors • Credentialed School Psychologists • Credentialed School Social Workers • Licensed Clinical Social Workers • Licensed Educational Psychologists • Licensed Marriage and Family Therapists • Licensed Physicians • Licensed Physician Assistants • Licensed Psychiatrists • Licensed Psychologists • Registered Associate Clinical Social Workers • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • Associate Marriage and Family Therapists must be registered with the California Board of Behavioral Sciences and require supervision by a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Psychologist, or a Licensed Physician and Surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. • Credentialed School Counselors must have a valid pupil personnel services credential with a specialization in school counseling. • Credentialed School Psychologists must have a pupil personnel services credential with a specialization in school psychology. • Credentialed School Social Workers must have a pupil personal services credential with a specialization in school social work. • Clinical Social Workers must be licensed to practice by the California Board of Behavioral Sciences and hold a valid pupil personnel services (PPS) credential issued by the Commission on Teacher Credentialing (CTC), with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Educational Psychologists must be licensed to practice by the California Board of Behavioral Sciences and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS credential holder.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Psychology and Counseling Services (cont.)**	Practitioner qualifications, limits and supervision requirements: • Marriage and Family Therapists must be licensed to practice by the California Board of Behavioral Sciences and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Psychiatrists must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Psychologists must be licensed to practice by the California Board of Psychology and hold a valid PPS credential issued by CTC, with the appropriate authorization for those services, or be appropriately supervised by a PPS-credential holder. • Associate Clinical Social Workers must be registered with the California Board of Behavioral Sciences and require supervision by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Clinical Psychologist, Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology. • Registered Credentialed School Nurses must be licensed to practice by the California Board of Registered Nursing and have a school nurse services credential.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Respiratory Care Services** Definition: Per 42 CFR § 440.60(a), federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care services, other than physician's services, provided by licensed practitioners within the scope of practice as defined under State law." Respiratory care services include, but are not limited to the assessment and therapeutic use of the following: • Oxygen therapy • Humidity therapy • Aerosol therapy • Air clearance techniques • Respiratory assist device • Chest physiotherapy • Assessment of patient's cardiopulmonary status Qualified Practitioner Type: • Licensed Respiratory Care Practitioners	Practitioner qualifications, limits and supervision requirements: • Respiratory Care Practitioners must be licensed by the Respiratory Care Board of California.

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Speech-Language and Audiology Services** Definition: Per 42 CFR § 440.110(c), services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided in an individual or group setting. It includes any necessary supplies and equipment. Qualified Practitioner Type: • Credentialed Audiologists • Credentialed Speech-Language Pathologists • Licensed Audiologists • Licensed Physicians • Licensed Physician Assistants • Licensed Speech-Language Pathologists • Registered School Audiometrists • Speech-Language Pathology Assistants The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR § 440.110.	Practitioner qualifications, limits, and supervision requirements: • Credentialed Audiologists must have a clinical or rehabilitative services credential with an authorization in audiology. • Credentialed Speech-Language Pathologists who have a preliminary or professional clear services credential in speech-language pathology may provide assessments and treatment services related to speech, voice, language, or swallowing disorders. Credentialed Speech-Language Pathologists who do not have a preliminary or professional clear services credential in speech-language pathology may provide services under the direction of a Licensed Speech-Language Pathologist or a Credentialed Speech-Language Pathologist who has a professional clear services credential in speech-language pathology. • Licensed Audiologists must be licensed to practice by the California Speech-Language Pathology and Audiology Board. • Physicians must be licensed to practice by the Medical Board of California or the Osteopathic Medical Board of California. • Physician Assistants must be licensed by the California Physician Assistant Board and require supervision by a Licensed Physician. • Licensed Speech-Language Pathologists must be licensed by the California Speech-Language Pathology and Audiology Board. • Registered School Audiometrists must have a valid certificate of registration issued by the Department of Health Care Services. • Speech-Language Pathology Assistants must register with the Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board and require supervision by a Licensed Speech-Language Pathologist or a Credentialed Speech-Language Pathologist.

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Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Specialized Medical Transportation Services** Definition: Per 42 CFR § 440.170(a)(1), "transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary. This service is limited to transportation of an eligible child to health related services as listed in a recipient's IEP/IFSP.	Service Limitations and requirements: • Specialized transportation services are available to Medicaid eligible beneficiaries for whom the transportation services are medically necessary and documented in an IEP/IFSP. • Services must be provided on the same date of service that a Medicaid covered service, required by the student's IEP/IFSP, is received. Both the transportation and the covered services must be authorized in the student's IEP/IFSP. • Transportation must be provided on a specially adapted vehicle to and/or from the location where the Medicaid service is received, and includes specialized transportation services that are provided in a litter van, wheelchair van, or a specially adapted vehicle equipped with adaptations, such as: lifts, ramps, and/or restraints driven by employees or contracted by the LEA.

STATE PLAN CHART

Type of Services	Program Coverage**	Prior Authorization or Other Requirements*
24g Local Educational Agency (LEA) Services (cont.) *Prior authorization is not required for emergency services. **Coverage is limited to medically necessary services.	**Targeted Case Management (TCM) Services** Definition: As defined in Supplement 1c to Attachment 3.1-A. <u>Qualified Practitioner Type:</u> • Associate Marriage and Family Therapists • Certified Nurse Practitioners • Certified Public Health Nurses • Credentialed School Counselors • Credentialed School Psychologists • Credentialed School Social Workers • Credentialed Speech-Language Pathologists • Licensed Clinical Social Workers • Licensed Educational Psychologists • Licensed Marriage and Family Therapists • Licensed Occupational Therapists • Licensed Physical Therapists • Licensed Psychologists • Licensed Registered Nurses • Licensed Speech-Language Pathologist • Licensed Vocational Nurses • Program Specialists • Registered Associate Clinical Social Workers • Registered Credentialed School Nurses	<u>Practitioner qualifications, limits and supervision requirements:</u> • A Registered Nurse, or a Public Health Nurse with a license in active status to practice as a registered nurse in California; individual shall have met the educational and clinical experience requirements as defined by the California Board of Registered Nursing, or • An individual with at least a Bachelor's degree from an accredited college or university, who has completed a LEA agency- approved case management training course, or • An individual with at least an Associate of Arts degree from an accredited college, who has completed a LEA agency-approved case management training course and has two years of experience performing case management duties in the health or human services field, or • An individual who has completed a LEA agency-approved case management training course and has four years of experience performing case management duties in a health or human services field.

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

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

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

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

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

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