STATE PLAN AMENDMENT
PROSPECTIVE PAYMENT REIMBURSEMENT

A. General Applicability

1. Notwithstanding any other provision of this State Plan, reimbursement to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the types of services described in this Amendment will be made as set forth below. This Amendment will apply to Medi-Cal Services furnished to Medi-Cal beneficiaries for purposes of implementing Section 1902(bb) of the Social Security Act (the Act).

2. Under the California Section 1115 Medicaid Demonstration Project for Los Angeles No. 11 W-00076/9 (LA Waiver), specified FQHCs (or "FQHC look alike clinics") received 100 percent cost-based reimbursement under the Special Terms and Conditions of that waiver. Beginning July 1, 2005, FQHCs that received cost-based reimbursement under the LA Waiver will be paid under the methodology described under Section I.

3. Any facility that first qualified as an FQHC or RHC (as defined in Section B) prior to the close of its fiscal year ending in calendar year 2000 was reimbursed through the prospective payment methodology described under Section D, unless, within 30 days of written notification from DHS, the facility elected to be reimbursed under the alternative payment methodology described under Section E. If the alternative payment methodology described under Section E was selected by the facility, the initial selection of a payment methodology remained in effect through September 30, 2002.

4. Prior to October 1, 2002, each FQHC and RHC was required to choose a reimbursement method and to inform DHS of its election. The choice was whether its reimbursement rate calculation, which was to serve as the basis for all future Medicare Economic Index (MEI) increases and scope-of-service changes, would be either of the following:

   (1) The prospective payment reimbursement methodology described under Section D.

   (2) The alternative payment reimbursement methodology described under Section E.

For purposes of this segment of the State Plan, relating to prospective reimbursement for FQHCs and RHCs, the MEI is the annual percentage increase in costs as defined in Section 1842(i)(3) of the Act for primary care services, defined in Section 1842(i)(4) of the Act. The MEI is published each year in the Federal Register. The base rate selected for purposes of reimbursement under the methodology described under Section D or Section E is inclusive of the MEI increases that applied prior to October 1, 2002, as described under Section D and Section E. An FQHC or RHC that failed to notify DHS of its election of the alternative payment methodology within 30 days of written notification was assigned a reimbursement rate calculated using the prospective payment methodology described under Section D.

5. Provider-based entities are defined as the following:

(a) An FQHC that was provider-based as of July 1, 1998, or that had provider-based status pending on April 22, 1999, and has received Medi-Cal payments based on its provider-based status continuously since that date, was paid under either the prospective payment methodology (Section D) or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its FQHC provider-based status. The term "appropriately adjusted" means that an FQHC's provider-based rate includes the amount of the hospital's total costs allocable to the FQHC. These costs are in addition to those costs directly attributable to the operation of the FQHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If an FQHC receives "FQHC provider-based" designation under Medicare, pursuant to 42 CFR Part 413.65(n), from CMS, the FQHC may apply to DHS for Medi-Cal provider-based FQHC reimbursement status. Upon verification of such status, the FQHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its FQHC provider-based status.

(b) In accordance with 42 CFR Section 491.3, an RHC that received provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", will continue to be paid under either the prospective payment methodology (Section D), or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its RHC provider-based status. The term "appropriately adjusted" in this context means that an RHC's provider-based rate includes the amount of the hospital's shared costs allocable to the RHC. These costs are in addition to those

costs directly attributable to the operation of the RHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If subsequent to the approval of this State Plan Amendment, an RHC receives provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", pursuant to 42 CFR Part 41 3.65, the RHC may apply to DHCS for Medi-Cal provider-based RHC reimbursement status pursuant to 42 CFR Part 491.3. Upon verification of such status, the RHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its RHC provider-based status.

6. An FQHC or RHC may elect to have pharmacy services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. An FQHC or RHC that elects to have pharmacy services reimbursed on a fee-for-service basis will not have its reimbursement rate for those services converted to a fee-for-service basis until the FQHC or RHC completes a scope-of-service rate change request and the adjustment to the prospective payment system reimbursement rate has been completed. An FQHC or RHC that reverses its election under this provision will revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period adjusted for any increase or decrease associated with an applicable scope-of-service change as provided in Section K.

B. FQHCs and RHCs Eligible for Reimbursement Under This Amendment

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Federally Qualified Health Center" or "Rural Health Clinic" in Section 1905(1)(2)(B), and Section 1905(1)(1), respectively, of the Act.

C. Services Eligible for Reimbursement Under This Amendment

1. (a) Services eligible for prospective or alternative payment reimbursement are covered benefits described in Section 1905(a)(2)(C) of the Act that are furnished by an FQHC and services described in Section 1905(a)(2)(B) of the Act that are furnished by an RHC. The services furnished will be reported to DHCS annually, in a format prescribed by DHCS.

(b) Optional services that are furnished by an FQHC and RHC within the scope of subparagraph C.1(a), or any other provision of this State Plan, are covered only to the extent that they are identified in the state plan segments entitled, "Limitations on Attachment 3.1-A" and "Limitations on Attachment 3.1-B" on pages 3 through 3e, effective July 1, 2009.

2. A "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:

(a) A face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse

midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.1.(a). For purposes of this subparagraph 2(a), "physician" includes the following:

(i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.

(ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.

(iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.

(iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

(b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner.

***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 4/1/2012.

3. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

   (a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

   (b) The clinic patient has a face-to-face encounter with a dentist and then also has a face-to-face encounter with any one of the following providers: physician (as defined in subparagraphs C.2(a)(i)-(iv)), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or a comprehensive perinatal services practitioner.

D. Prospective Payment Reimbursement

An FQHC or RHC that does not elect the alternative payment reimbursement methodology under Section E will receive reimbursement under the following prospective payment reimbursement methodology provisions:

1. On July 1, 2001, DHS implemented a prospective payment reimbursement methodology on a phased-in basis. Each FQHC or RHC receives payment in an amount calculated using the methodology described under paragraphs D.2 and D.4 effective the first day of the fiscal year on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section D became effective for a particular facility, each FQHC or RHC was paid in accordance with Section H.

2. (a) Beginning on January 1, 2001, the prospective payment reimbursement rate for an FQHC or RHC was equal to 100 percent of the average reported cost-based reimbursement rate per visit for fiscal years 1999 and 2000 for the FQHC or the RHC, as determined in accordance with cost reimbursement principles for allowable costs explained in 42 CFR Part 413, as well as, Generally Accepted Accounting Principles. For each FQHC or

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph D.2(a) was calculated using a visit definition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week, or mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity, as well as, licensed or enrolled as a Medi-Cal provider.

4. Effective October 1st of each year, for services furnished on and after that date, DHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section 1842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

1. Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section E became effective for the

particular facility, the FQHC or RHC was paid in accordance with Section H.

(a) Payments made to each FQHC or RHC in accordance with the alternative payment reimbursement methodology set forth in this Section E will be an amount(calculated on a per-visit basis) that is, equal to its reported cost-based rate (based on allowable costs) for the particular facility's fiscal year ending in calendar year 2000, increased by the percentage increase in the MEI. DHS determines all rates in accordance with cost reimbursement principles in 42 CFR Part 413, and with Generally Accepted Accounting Principles..

(b) (i) Each participating FQHC's or RHC's reported cost-based reimbursement rate (calculated on a per-visit basis) for the particular facility's fiscal year ending in calendar year 2000 serves as its prospective payment reimbursement rate under the alternative payment reimbursement methodology.

(ii) If the cost per visit for the period used to establish the alternative payment methodology rate in subparagraph E.1(b)(i) was calculated using a visit definition that does not conform with Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certification of accuracy within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC in determining if a rate adjustment was necessary. Subparagraph E.1(b)(ii) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

(c) As described in more detail below, the prospective payment reimbursement rate is increased by the percentage increase in the MEI applicable to primary care services, defined in Section 1842(i)(4) of the Act, for the particular calendar year as published in the Federal Register.

(d) Beginning July 1, 2001 and thereafter, the MEI increase is applicable to the period starting with the mid-point of each FQHC's or RHC's fiscal year through the mid-point of the rate periods (January 1, 2001 through June 30, 2001 and July 1, 2001 through September 30, 2002).

For example, if a FQHC or RHC had a June 30th fiscal year end, the period determining the first MEI increase was December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) through April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30, 2001). The period determining the second MEI increase was April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If a FQHC or a RHC has a December 31st fiscal year end, the period determining the first MEI increase was June 30, 2000 through April 1, 2001. As in the previous example, the period determining the second MEI increase was April 1, 2001 through February 15, 2002.

(e) In accordance with Section 1902(bb)(6)(B) of the Act, in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, the rate must be no less than the rate calculated using the methodology described in Section D.

2. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week or in mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when it is owned or operated by the same entity and is licensed or enrolled as a Medi-Cal provider.

3. Beginning October 1, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHS will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.1(c), above).

F. Alternative Payment Methodology for an Existing FQHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DHS will establish a rate (calculated on a per-visit basis) that is equal to either of the following (as selected by the FQHC or RHC):

(a) The average of the rates established for three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph is subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal

year of the facility's operation at the newly relocated site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

2. A rate established for an existing FQHC or RHC under this Section F is effective for visits occurring at the new facility.

G. Payment Methodology for Extraordinary Circumstances

1. Supplemental payments, in proportion to the Medi-Cal services provided by the facility, may be established in accordance with this Amendment to reflect the net realized additional costs (as approved by DHS), not otherwise reimbursed by other sources, incurred as a result of extraordinary circumstances attributed to any of the following:

   (a) Acts of nature (e.g., flood, earthquake, lightning, or storms).

   (b) Acts of terrorism.

   (c) Acts of war.

   (d) Riots.

   (e) Changes in applicable requirements in the Health and Safety Code.

   (f) Changes in applicable licensing requirements.

   (g) Changes in state or federal laws or regulations applicable to FQHCs or RHCs.

2. The supplemental payment provided for in this Section G will apply only to the extent, and only for the period of time, that the additional costs for the event specified in paragraph G.1 are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation.

3. Where applicable, the supplemental payment provided in this Section G will be governed by cost reimbursement principles identified in 42 CFR

Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

4. A request for supplemental payment will be accepted by DHS at any time in the prospective payment rate year. A request will be submitted for each affected year. A written request under this Section G must be made to DHS for its consideration and must include differences in costs and visits, if applicable, associated with operations before and after the event specified in paragraph G.1. Documentation in a manner and form specified by DHS showing the cost implications must be submitted. A supplemental payment will not be paid unless the cost impact will be material and significant (two hundred thousand dollars ($200,000) or 1.0 percent of an FQHC's or RHC's total costs, whichever is less).

5. DHS will decide whether a request for supplemental payment will be granted, and the amount of such payment. Amounts granted for supplemental payment requests will be paid as lump-sum amounts for those years and not as revised PPS rates. The FQHC or RHC must repay the unspent portion of the supplemental payment to DHS if it does not expend the full amount of the supplemental payment to meet costs associated with the catastrophic event.

6. The supplemental payment provided in this Section G is independent of a rate adjustment resulting from a scope-of-service change in accordance with Section K and will only be made for a qualifying event as described in this Section G. Costs eligible for a supplemental payment under this Section will be proportionate to the Medi-Cal services provided by the facility, determined utilizing a cost report format as specified by DHS, and will not include payment for any costs recovered as scope-of-service rate change(s) under Section K.

7. When determining eligibility for a supplemental payment, the FQHC or the RHC must show that its PPS rate is not sufficient to cover the costs associated with the extraordinary circumstance. If the PPS rate is sufficient to cover the costs associated with the events specified in paragraph G.1, or the PPS rate was adjusted to compensate the events specified in paragraph G.1, then no supplemental payment will be made.

H. Alternative Payment Methodology for Retroactive Reimbursement

1. For the period January 1, 2001, until the date that a particular FQHC or RHC begins to receive payment pursuant to the methodology set forth in Section D or Section E, such FQHC or RHC may elect to retroactively receive reimbursement under Section D or Section E, or to decline such reimbursement. An FQHC or RHC that fails to make an election within 30 days of written notification from DHS will receive retroactive payment

to January 1, 2001, under the prospective payment methodology described under Section D.

2. An FQHC or RHC that elected in writing to decline retroactive reimbursement under both Section D and Section E may continue to be paid under the cost-based reimbursement methodology as in effect prior to BIPA 2000 until payments under Section D or Section E take effect, subject to the requirements of Section 1902(bb)(6) of the Act, and to cost reconciliation when appropriate.

I. Alternative Payment Methodology for FQHCs Participating Under the LA Waiver

1. The LA Waiver expired on July 1, 2005. FQHCs participating in the LA Waiver that were established as an FQHC (as defined in Section B) prior to 1999 and elected to remain under cost-based reimbursement must convert to a prospective payment system reimbursement rate, effective July 1, 2005. FQHCs as described above must choose one of the following options for calculating their prospective payment system reimbursement rate:

   (a) Utilize the average of their "as reported" FY 1999 and FY 2000 cost reports, plus adjustments for the annual MEI increases described under paragraphs D.2-5.

   (b) Utilize only the "as reported" FY 2000 cost report, plus adjustments for annual MEI increases as described under subparagraph E.1(a)-(e) and paragraph E.3.

2. On October 1, 2005 and each October 1st thereafter, DHS will adjust the rate established under subparagraphs I.1(a) or (b) by the applicable percentage increase in the MEI, as specified in paragraph D.4 or paragraph E.3.

3. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 1999, but prior to the close of their FY 2000 will have their prospective payment system reimbursement rate calculated according to the methodology described in subparagraph I.1(b) above, and will have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

4. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 2000 will have their prospective payment system reimbursement rate calculated based on the first full fiscal year "as audited" cost report adjusted by the applicable MEI increase(s) to bring the prospective payment system reimbursement rate current to July 1,

2005, and will also have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

5. FQHCs that failed to elect an option by June 30, 2005, under either subparagraphs I.1(a) or (b) above, will be assigned the prospective payment system reimbursement rate described in Section I.1(a).

6. FQHCs participating in the LA Waiver that had applicable scope-of-service change(s) prior to July 1, 2005, must submit a scope-of-service change request describing the qualifying event. FQHCs must submit a scope-of-service change request no later than July 1, 2006.

J. Rate Setting for New Facilities

1. For the purpose of this Section J, a new facility is an FQHC or RHC (as defined in Section B) that meets all applicable licensing or enrollment requirements, and satisfies any of the following characteristics:

   (a) First qualifies as an FQHC or RHC after its fiscal year ending on or after calendar year 2000.

   (b) A new facility at a new location is added to an existing FQHC or RHC and is licensed or enrolled as a Medi-Cal provider.

2. DHS will require that the new facility identify at least three comparable FQHCs or RHCs providing similar services in the same or an adjacent geographic area with similar caseload. If no comparable FQHCs or RHCs are in operation in the same or an adjacent geographic area, the new facility will be required to identify at least three comparable FQHCs or RHCs in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics. If the facility is unable to identify three comparable FQHCs or RHCs, DHS will identify at least three comparable facilities with respect to relevant social, health care, and economic characteristics.

3. At a new facility's one time election, DHS will establish a rate (calculated on a per visit basis) that meets the requirements of Section 1902(bb)(4) of the Act and that is equal to one of the following:

   (a) The average of the rates established for the three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph will be subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

4. If a new facility does not respond within 30 days of DHS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), DHS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

5. The effective date for the rate of a new facility under Section J is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.

   (a) An FQHC or RHC may continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than 20 hours per week or in mobile facilities.

   (b) DHS will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following notification to the provider that its FQHC or RHC number has been activated.

6. In order to establish comparable FQHCs or RHCs providing similar services, DHS will require all FQHCs or RHCs to submit to DHS either of the following:

(a) Its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report.

(b) A similar report utilizing a format as specified by DHS applicable to the prior calendar year.

FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit a completed report in the format used in the prior calendar year. A new FQHC or RHC that has not previously submitted an annual utilization report will submit an annual utilization report or similar report as specified by DHS.

K. Scope-of-Service Rate Adjustments

An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope-of-services provided by the FQHC or RHC, subject to all of the following:

1. A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

   (a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.

   (b) The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

   (c) The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

   (d) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold will be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

2. Rate changes based on a change in the scope-of-services provided by an FQHC or RHC will be evaluated in accordance with Medicare reasonable cost principles, as set forth in 42 CFR Part 413, or its successor. Subject

to the conditions set forth in subparagraphs (a) through (d), inclusive, of paragraph (1), a change in scope-of-service means any of the following:

(a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.

(b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) An increase in the intensity of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites.

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C.1.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section K, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

5. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by DHS.

6. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and subsequent fiscal years will be calculated as follows:

(a) If DHS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

(b) The difference computed as in 6(a), between the newly calculated cost per-visit rate and the current PPS per-visit rate, is then multiplied by an 80 percent adjustment factor to arrive at an amount that is to be considered applicable to a scope-of-service adjustment for that year.

(c) That 80 percent adjustment amount is then added to the current PPS rate and the newly established rate becomes the newly adjusted PPS reimbursement rate, effective the first day following the fiscal year end that the FQHC or RHC submitted the documentation for the scope-of-service change. For example, a FQHC or RHC has a:

(i) Newly established per-visit rate of $115.00,

(ii) Current PPS per-visit rate of $95.00,

(iii) July 1, 2003, to June 30, 2004, fiscal year and a

(iv) Scope-of-service change date of February 15, 2004.

The newly established PPS rate is calculated and effective as follows:

(v) $20.00 is the difference between the newly established per-visit rate ($115.00) and the current PPS rate ($95.00),

(vi) $16.00 is the 80 percent adjustment amount ($20.00 X 80 percent),

(vii) $111.00 is the newly established PPS rate ($95.00 + $16.00),

(viii) July 1, 2004, is the date the $111.00 rate becomes effective.

(ix) The MEI will be applied to the PPS rate established in calendar year 2004 and subsequent fiscal years on the first day of October that is not within the particular FQHC's or RHC's fiscal year. For any FQHC or RHC that has a July 1, 2003, to June 30, 2004, fiscal year (as described in the example above), October 1, 2004, is the date of the MEI, which will be applied to the July 1, 2004, established PPS rate. For any FQHC or RHC that has a January 1, 2004 to December 31, 2004, fiscal year, October 1, 2005, is the

date the MEI will be applied to the January 1, 2005, established PPS rate.

(d) For scope-of-service changes implemented between the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001 and the last day of the FQHC's or RHC's fiscal year ending in calendar year 2003, the reimbursement rate will be calculated by taking the difference between the newly established per-visit rate and the initial PPS rate, then multiplying the difference by 80 percent for either two or three periods, depending on when the scope-of-service change occurred and when the cost report is filed. For example, an FQHC or RHC has a:

(i) Newly established per-visit rate of $120.00,

(ii) Initial PPS rate of $95.00,

(iii) July 1, 2002, to June 30, 2003, fiscal year, and

(iv) Scope-of-service change date of February 15, 2001.

Then the retroactive PPS rate for the fiscal years in question is calculated and becomes effective as follows:

(v) $25.00 is the difference between the newly established per-visit rate ($120.00) and the initial PPS rate ($95.00),

(vi) $20.00 is the 80 percent adjustment amount ($25.00 X 80%) for the July 1, 2002, to June 30, 2003, period, is added to the initial PPS rate for a PPS rate of $115.00 ($95.00 + $20.00), and is effective July 1, 2002, to September 30, 2003,

(vii) $16.00 is the 80 percent adjustment factor ($20.00 X 80%) for the July 1, 2001, to June 30, 2002, period, is added to the initial PPS rate for a PPS rate of $111.00 ($95.00 + $16.00), and is effective July 1, 2001, to June 30, 2002,

(viii) $12.80 is the 80 percent adjustment amount ($16.00 X 80%) for the January 1, 2001, to June 30, 2001, period, is added to the initial PPS rate for a PPS rate of $107.80 ($95.00 + $12.80), and is effective February 15, 2001, to June 30, 2001.

(ix) The MEI will be applied to the PPS rate established in calendar 2003 on the first day of October that is not within

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

7. A written request under Section K must be made to DHS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHS. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

8. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(1)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1. will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the methodology described in Section D, E, or J, and, if applicable, Section F.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D, E, or J, and, if applicable, Section G.

(c) If the amount calculated under the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D, E, or J, and, if applicable, Section G amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs 1 and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to be excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

1. Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DHS will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

N. Alternative Payment Methodology for FQHCs and RHCs that Elect to Provide Dental Hygienist Services or Dental Hygienist in Alternative Practice Services as a Billable Visit

1. An FQHC or RHC may, on or after January 1, 2008, elect to provide the services of a dental hygienist or dental hygienist in alternative practice as a separate and discreet "billable visit" under an alternative payment methodology (APM). Multiple encounters with dental professionals that take place on the same day will constitute a single visit. For purposes of this Section N, the term "dental hygienist in alternative practice" means a person licensed pursuant to Section 1774 of the California Business and Professions Code.

2. An FQHC or RHC has an option to provide dental hygienist services or dental hygienist in alternative practice services as a billable visit, in the following situations:

   (a) For those FQHCs or RHCs that have the cost of dental hygienist services or dental hygienist in alternative practice services included in their PPS reimbursement rate on or before January 1, 2008, and continue to provide those services, the FQHC or RHC may elect to have these services billed as a billable visit under this Section N. However if the APM total reimbursement results in an amount that is less (in the aggregate -- defined in paragraph N.2(c)) than under the methodology described in Section D, E, F, I, J, or K, whichever is applicable, then the FQHC or RHC will be compensated in accordance with the reconciliation process as defined in paragraph N.2.(e) below.

   If an FQHC or RHC requests the APM, including separate billable visits, the FQHC or RHC must submit appropriate form(s) as prescribed by DHCS in order for DHCS to recalculate the PPS reimbursement rate to an APM reimbursement rate described in this Section N. The recalculated reimbursement rate will include the services of a dental hygienist or dental hygienist in alternative practice as a billable visit.

   An FQHC or RHC that elects to have its PPS reimbursement rate recalculated under an APM reimbursement rate pursuant to this paragraph N.2 may continue to bill for all other FQHC or RHC visits at its existing per-visit PPS reimbursement rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or dental hygienist in alternative practice has been approved. Any approved APM reimbursement rate shall be calculated within six months after the date that DHCS receives the FQHC's or RHC's form(s) as prescribed by DHCS. DHCS will also complete a revenue reconciliation (defined in paragraph N.2(e)) of the approved APM reimbursement rate to ensure that the APM total reimbursement results in an amount that is no less (in the aggregate -- defined in paragraph N.2 (c)) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. An approved APM reimbursement rate will be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case will the effective date be earlier than January 1, 2008.

No scope-of-service change request for dental hygienist services or dental hygienist in alternative practice services will be considered for an FQHC or RHC that elects the APM reimbursement rate pursuant to this paragraph N.2(a).

(b) If an FQHC or RHC did not provide the services of a dental hygienist or dental hygienist in alternative practice before January 1, 2008, and later adds these services, a scope-of-service change may be requested as provided in Section K. After a scope-of-service change to add the additional service has been calculated and the PPS reimbursement rate has been revised to include the new service, an FQHC or RHC may elect the option to have dental hygienist services or dental hygienist in alternative practice services be reimbursed as a billable visit under the APM described in this Section N.

(c) For purposes of this Section N, "in the aggregate" when referenced with respect to the APM, is defined as the total revenue a facility would receive, calculated by multiplying the applicable reimbursement rate by the total number of services provided by dental hygienist or dental hygienist in alternative practice services in a given year and adding that revenue to the PPS reimbursement rate multiplied by the total number of services provided in given year that are compensated using the PPS reimbursement rate.

(d) For purposes of this Section N, "in the aggregate" when referenced with respect to the reimbursement rate under Section D, E, F, I, J, or K is defined as the total reimbursement which an FQHC or RHC would have been received using a PPS reimbursement rate (which does not include the services of a dental hygienist or dental hygienist in alternative practice as separate, billable visits) multiplied by the total number of services provided in a given year that are compensated using the PPS reimbursement rate.

(e) If the estimated total aggregate revenue for an FQHC or RHC under paragraph (d) above is greater than what the FQHC or RHC received in accordance with paragraph (c) above, DHCS will reimburse an FQHC or RHC for the difference between the amount it received in accordance with paragraph (c) above and the amount it would have received in accordance with paragraph (d) above. This process applies to the circumstance described in the first paragraph of paragraph N.2(a).

3. For FQHCs or RHCs that fall under one of the circumstances described in subparagraph N.2(a) or (b) above, and elect readjustment of their reimbursement rate under this Section N, DHCS shall recalculate the rate and make the appropriate rate adjustment as an APM as long as the FQHC or RHC agrees to the APM reimbursement rate and if the APM results in a total reimbursement that is no less (in the aggregate) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. In circumstances where the APM results in a total reimbursement that is less than what the FQHC or RHC would have received under Section D, E, F, I, J, or K, whichever is applicable, DHCS will complete a revenue reconciliation as described in paragraph N.2.(d).

O. Additional Provisions Regarding Multiple Encounters

In addition to the multiple encounters as provided in paragraph C.3(b), more than one visit may be counted on the same day when the FQHC or RHC patient has a face-to-face encounter with a dental hygienist, or dental hygienist in alternative practice, and then also has a face-to-face encounter with any non-dental health provider, as provided in paragraph C.3(b). Multiple encounters with a dentist and a dental hygienist or dental hygienist in alternative practice that take place on the same day will constitute a single visit.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY:

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: [ ] No limitations [X] With limitations*

2. a. Outpatient hospital services.

   Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   [X] Provided: [ ] No limitations [X] With limitations*

   [ ] Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   [X] Provided: [ ] No limitations [X] With limitations*

   d. Ambulatory services offered by a health center receiving funds under Section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   [X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

   Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided _____ No limitations __X__ With limitations

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is elected by the State.

__X__ Provided _____ No limitations __X__ With limitations

Please describe any limitations:

4.c.1 Family planning-related services provided under the above State Eligibility Option.

4. d. 1) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women Provided:

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide and receive payment for covered services *other* than tobacco cessation services;

*Description provided on attachment.

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

__X__ Provided _____ No limitations __X__ With limitations

The State is providing one (1) face-to-face counseling session per quit attempt, with a mandatory referral to a tobacco cessation quitline.

Face-to-face counseling (including assessment) for pregnant women will be consistent with the intervention as described in the "Treating Tobacco Use and Dependence-2008 Update: A Clinical Practice Guideline" published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline and shall include a mandatory referral to a tobacco cessation quitline. Counseling services are covered for the prenatal period through the postpartum period (the end of the month in which the 60 day period following termination of the pregnancy ends).

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided _____ No limitations __X__ With limitations

5.a.1 Sign language interpreter services (in connection with physician's services).

__X__ Provided _____ No limitations __X__ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided _____ No limitations __X__ With limitations

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services

__X__ Provided _____ No limitations __X__ With limitations

*Description provided on attachment.

State/ Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☐ Provided ☐ No limitations ☐ With Limitations*

☒ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of limitations, if any.

☐ Not provided.

7. Home health services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: ☐ No limitations ☒ With Limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With Limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, prosthetic devices, and hearing aids; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Prosthetic devices and hearing aids.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Eye glasses.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

*Description provided on attachment

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

c. Preventive services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physicians as having a substance-related disorder. (See Supplements 2 and 3 to Attachment 3.1-A):

/X/ Provided /__/ No limitations /X/ With limitations*

/__/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Skilled nursing facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

c. Intermediate care facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided:

17. Nurse-midwife services

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided: [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not provided:

*Description provided on attachment

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1f to ATTACHMENT 3.1-A for Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided __X__ With limitations* _____Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__X__ Provided __X__ With limitations* _____Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

_____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in Accordance with section1920 of the Act).

X Provided: ____ No Limitations X With limitations*
Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

Provided: ____ No Limitations ____ With limitations*
X Not provided.

23. Certified pediatric or family nurse practitioners' services.
Provided: ____ No Limitations X With limitations*

* Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

e. Emergency hospital services.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

/XX/ Not provided.

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services

|X| Provided: | | No limitations |X| With limitations*

| | Not provided.

*Description provided on attachment.

State: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work.

_X_ Provided: _X_ State Approved (Not Physician) Service Plan Allowed
_X_ Services Outside the Home Also Allowed

_X_ Limitations Described on Attachment

___ Not Provided.

State of California
PACE State Plan Amendment Pre-Print

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

28. X Self-Directed Personal Assistance Services, as described in Supplement 5 to Attachment 3.1-A.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

___ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

29.a Licensed or otherwise State-approved Alternative Birth Centers

Provided: ☐ No limitations ☒ With limitations* ☐ None licensed or approved

29.b Licensed or otherwise State-recognized covered professionals providing services in the Alternative Birth Center.

Provided: ☐ No limitations ☒ With limitations*

☐ Not Applicable (there are no licensed or State approved Alternative Birth Centers)

☒ 1) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan.

☒ 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 whose services are otherwise covered under 42 CFR 440.60.

☐ 3) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services.

* Description provided on attachment

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

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

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

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

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

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

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

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

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

* Prior authorization is not required for emergency service.

**Coverage is limited to medically necessary services

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

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

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

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

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

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

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

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

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

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

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3	Laboratory, radiological, and radioisotope services	As required on order of a licensed practitioner except laboratory services provided in renal dialysis centers and community hemodialysis units are payable only when billed by the center or unit.	Prior authorization is required for nonemer gency portable X-ray services unless perfo 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 patie level of care and plan every 60 days. For patients having Medicare as well as Med eligibility (crossover cases), authorizatio required at the time of Medicare denial <u>or</u> <u>before</u> the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA #88-17 Eff 7-1-88 App MAR 2 1 19

(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.

SPMH 88-17

EFF 7-1-88

App [illegible] 1988

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHAM 88-17

Eff 9-1-88

App. MAR 2 1 1989

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 4168 17

Eff 7-1-80

App MAR 2 1 1980

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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

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

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

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

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

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

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

* 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.

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

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

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.	Covered for Medi-Cal eligibles under 21 years of age.	Prior authorization is not required.
	Includes rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day care intensive, day care habilitation offered in local and mental health clinics or in the community.	Medical necessity is the only limitation.
	Includes Local Education Agency (LEA) Medi-Cal Billing Option Program services (LEA services). LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.	Service Limitations LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student, • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management).

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

STATE PLAN CHART

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

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

TN No. 05-010
Supersedes
TN No. 03-024

Approval Date DEC 16 2011

Effective Date: October 1, 2009

STATE PLAN CHART

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

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

STATE PLAN CHART

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

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

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)		• The definition of "under the direction of" a licensed audiologist, licensed speech-language pathologist or credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology is that the practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed practitioners that he or she agrees to direct. The practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.
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 properly obtained 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 service.
**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)	Outpatient medical procedures such as hyperbaric 0^2 therapy, psoriasis day care, apheresis, cardiac 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.
	Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.	Prior authorization is required for psychiatric services in excess of 8 services in each 120-day period and injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.

* 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*
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.	In accordance with 42 U.S.C. Section 1396d (a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.	Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

STATE PLAN CHART

(Note: This chart is an overview only.)

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 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

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICES	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 limited to one service in a 24 month period.	

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

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

Routine nail trimming is not covered.

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

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

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

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

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

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

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

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

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

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

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4	Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7.	Home Health Services Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.	Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services: 1. Skilled nursing services as provided by a nurse licensed by the state 2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110. 3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110 4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110. 5. Home health aide services provided by a Home Health Agency Medical supplies, equipment, and appliances suitable for use in the home.	
7a. 7b.	Home health nursing and aide services	Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

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

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1	Medical supplies	As prescribed by a licensed practitioner within the scope of his or her practice. 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 supplie listed in the Medical Supplies Formulary. Certain items require authorization unless for the conditions specified in the Medical Supplies Formulary.
		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 b supplying the blood or facility where transf is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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

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

TN 11-012
Supersedes
TN 03-12

Approval date: SEP 12 2011

Effective date: 11/1/2011

STATE PLAN CHART

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
9 Clinic Services (continued)	The following services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.	
10 Dental services	Pursuant to 42 U.S.C. Section 1396d (a)(10), dental services are covered as described under this plan only for the following beneficiaries: 1. Pregnant women: emergency dental services and pregnancy related-services or services to treat a condition that may complicate the pregnancy. 2. Individuals who are eligible for the EPSDT program: emergency dental services and all other medically necessary dental services. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits. For eligible beneficiaries 21 years of age and older (non-EPSDT), an $1,800 annual benefit maximum applies, with the following exceptions: • Emergency dental services • Services including pregnancy-related services and for other conditions that might complicate the pregnancy. • Dentures • Dental implants and implant-retained prostheses.	Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). The Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization is required in general for crowns (except stainless steel crowns), root canal treatments, treatment of periodontal disease, dentures, implants, some complex oral surgical procedures, and orthodontic treatment. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

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

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

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance and acquisition of skills and audiology may be provided only upon the written prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. 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. Speech therapy and audiology services are covered in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries. Speech therapy and audiology services are covered under this state plan only for the following beneficiaries: 1. Pregnant women, if the speech therapy and audiology services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program.	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.

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

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

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

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

STATE PLAN CHART

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

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

STATE PLAN CHART

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

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

State Plan Chart

(Note: This chart is an overview only.)

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

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

(Note: This chart is an overview only.)

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

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

(Note: This chart is an overview only.)

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

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

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

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

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

* Prior authorization is not required for emergency services.
** 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

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

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

(Note: This chart is an overview only)

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

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

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

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

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

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

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

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

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

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

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

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

STATE PLAN CHART

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

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

STATE PLAN CHART

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

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

STATE PLAN CHART

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

*Prior Authorization is not required for emergency service.

**Coverage is limited to medically necessary services.

STATE PLAN CHART

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

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

STATE PLAN CHART

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

*Prior Authorization is not required for emergency service.

**Coverage is limited to medically necessary services.

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

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

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

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

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

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

...on: HCFA-PM-86-20 (BERC)
...EMBER 1986

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

*Description provided on attachment.

MEDI-CAL BENEFITS CHART

Supplement to Attach 3.1
RNS/R

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   [X] Provided: [ ] No limitations [X] With limitations*

2. a. Outpatient hospital services.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   [X] Provided: [ ] No limitations [X] With limitations*

   d. Ambulatory services offered by a health center receiving funds under Section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   [X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

   [X] Provided: [ ] No limitations [X] With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Family planning services and supplies for individuals of childbearing age.

   [X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

4. d. 1) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women Provided:

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide and receive payment for covered services *other* than tobacco cessation services;

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

__X__ Provided _____ No limitations __X__ With limitations

The State is providing one (1) face-to-face counseling session per quit attempt, with a mandatory referral to a tobacco cessation quitline.

Face-to-face counseling (including assessment) for pregnant women will be consistent with the intervention as described in the "Treating Tobacco Use and Dependence-2008 Update: A Clinical Practice Guideline" published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline and shall include a mandatory referral to a tobacco cessation quitline. Counseling services are covered for the prenatal period through the postpartum period (the end of the month in which the 60 day period following termination of the pregnancy ends).

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided _____ No limitations __X__ With limitations

5.a.1 Sign language interpreter services (in connection with physician's services).

__X__ Provided _____ No limitations __X__ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided _____ No limitations __X__ With limitations

*Description provided on attachment.

State/ Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☒ Provided: ☐ No limitations ☒ With Limitations*

b. Optometrists' services.

☐ Provided ☐ No limitations ☐ With Limitations*

☒ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

d. Other practitioners' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

7. Home health services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With Limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With Limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With Limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO MEDICALLY NEEDY GROUP(S) _____

8. Private duty nursing services.

☐	Provided:	☐	No limitations	☐	With limitations*

9. Clinic services.

☒	Provided:	☐	No limitations	☒	With limitations*

10. Dental Services.

☒	Provided:	☐	No limitations	☒	With limitations*

11. Physical therapy and related services.

a. Physical therapy.

☒	Provided:	☐	No limitations	☒	With limitations*

b. Occupational therapy.

☒	Provided:	☐	No limitations	☒	With limitations*

c. Services for individuals with speech, hearing and language disorders provided by or under supervision of a speech pathologists or audiologist.

☒	Provided:	☐	No limitations	☒	With limitations*

12. Prescribed drugs, dentures, prosthetic devices, and hearing aids; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒	Provided:	☐	No limitations	☒	With limitations*

b. Dentures.

☒	Provided:	☐	No limitations	☒	With limitations*

*Description provided on attachment

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS

c. Prosthetic devices and hearing aids.

__X__ Provided _____ No limitations __X__ With limitations

d. Eye Glasses.

__X__ Provided _____ No limitations __X__ With limitations

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostics services

_____ Provided _____ No limitations ___With limitations

b. Screening services

_____ Provided _____ No limitations ___With limitations

c. Preventive services.

__X__ Provided _____ No limitations __X__ With limitations

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physician as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B)

__X__ Provided _____ No limitations __X__ With limitations

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

__X__ Provided _____ No limitations __X__ With limitations

b. Skilled nursing facility services

__X__ Provided _____ No limitations __X__ With limitations

*Description provided on attachment.

NOV 0 7 2013

Approval Date: _____

Effective Date: 1/1/2013

State/Territory: California

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

c. Intermediate care facility services.

[X] Provided: [ ] No limitations [X] With limitations*

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

[X] Provided: [ ] No limitations [X] With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided: [ ] No limitations [X] With limitations*

16. Including psychiatric facility services for individuals under 22 years of age.

[X] Provided: [ ] No limitations [X] With limitations*

17. Nurse-midwife services.

[X] Provided: [ ] No limitations [X] With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided: [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations*

*Description provided on attachment

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
TO THE MEDICALLY NEED GROUP(S): _____

19. Case management services and Tuberculosis related activities

a. Case management services as defined in, and to the group specified in, Supplemental 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1h to ATTACHMENT 3.1-A for County-Funded Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: __X__ With limitations* _____ Not provided

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__X__ Provided: __X__ With Limitations* _____ Not provided

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Provided: + _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Provided: + _____ Additional coverage ++ _____ Not provided

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided: _____ No Limitation __X__ With limitations*
_____ No provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services of services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act)

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Services of Christian Science nurses.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Care and services provided in Christian Science sanitoria.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services
X Provided: ___ No Limitations X With Limitations*
___ Not Provided

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal Care Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work. PJD

X Provided: X State Approved (Not Physician) Service Plan Allowed
X Services Outside the Home Also Allowed
X Limitations Described on Attachment
PJD

__ Not Provided:

* Decription provided on attachment.

State of California
PACE State Plan Amendment Pre-Print

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-B.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

27. X Self-Directed Personal Assistance Services, as described in Supplement 5 to Attachment 3.1-B.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

___ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

28.a Licensed or otherwise State-approved Alternative Birth Centers

Provided: ☐ No limitations ☒ With limitations*

28.b Licensed or otherwise State-recognized covered professionals providing services in the Alternative Birth Center.

Provided: ☐ No limitations ☒ With limitations*

☐ Not Applicable (there are no licensed or State approved Alternative Birth Centers)

☒ 1) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan.

☒ 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 whose services are otherwise covered under 42 CFR 440.60.

☐ 3) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services.

* Description provided on attachment

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

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-B

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-B

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of a physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3. Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing. 4. Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours. 5. Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

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

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

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

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

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

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

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

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

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

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

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

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

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

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHERE-17

Eff 7-1-88

App MAR 3 1 19

(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 tw months. Prolonged care may be authorized for up to 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

App 1 1989

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHILCC-17

Eff 1-1-88

App. MAR 2 1 1989

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 4168 17

Eff 7-1-80

App MAR 21 1989

(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH-H 86-17

Eff 7-1-87

App MAR 2 1 1990

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 that 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.

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

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

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.	Covered for Medi-Cal eligibles under 21 years of age.	Prior authorization is not required.
	Includes rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day care intensive, day care habilitation offered in local and mental health clinics or in the community.	Medical necessity is the only limitation.
	Includes Local Education Agency (LEA) Medi-Cal Billing Option Program services (LEA services). LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.	Service Limitations LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student, • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management).

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

TN No. 05-010
Supersedes
TN No. 03-024

Approval Date DEC 16 2011

Effective Date: October 1, 2009

STATE PLAN CHART

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

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

TN No. <u>05-010</u>
Supersedes
TN No. <u>03-024</u>

Approval Date DEC 16 2011

Effective Date: <u>October 1, 2009</u>

STATE PLAN CHART

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

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

STATE PLAN CHART

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

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

TN No. <u>05-010</u>
Supersedes
TN No. <u>03-024</u>

Approval Date DEC 16 2011

Effective Date: <u>October 1, 2009</u>

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)		• The definition of "under the direction of" a licensed audiologist, licensed speech-language pathologist or credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology is that the practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed practitioners that he or she agrees to direct. The practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.
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 properly obtained 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 service.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)	Outpatient medical procedures such as hyperbaric 0^2 therapy, psoriasis day care, apheresis, cardiac 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.
	Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.	Prior authorization is required for psychiatric services in excess of 8 services in each 120-day period and injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.

* 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*
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.	In accordance with 42 U.S.C. Section 1396d (a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.	Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

STATE PLAN CHART

(Note: This chart is an overview only.)

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 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

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICES	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 limited to one service in a 24 month period.	

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

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

Routine nail trimming is not covered.

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

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

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

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

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

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

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

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

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

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

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4	Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

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

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7.	Home Health Services Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.	Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services: 1. Skilled nursing services as provided by a nurse licensed by the state 2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110. 3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110 4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110. 5. Home health aide services provided by a Home Health Agency Medical supplies, equipment, and appliances suitable for use in the home.	
7a. 7b.	Home health nursing and aide services	Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

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

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1	Medical supplies	As prescribed by a licensed practitioner within the scope of his or her practice. 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 supplie listed in the Medical Supplies Formulary. Certain items require authorization unless for the conditions specified in the Medical Supplies Formulary.
		Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donation cannot be obtained is required from blood b supplying the blood or facility where transf is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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

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

STATE PLAN CHART

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
9 Clinic Services (continued)	The following services are subject to a two-services limit in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.	
10 Dental services	Pursuant to 42 U.S.C. Section 1396d (a)(10), dental services are covered as described under this plan only for the following beneficiaries: 1. Pregnant women: emergency dental services and pregnancy related-services or services to treat a condition that may complicate the pregnancy. 2. Individuals who are eligible for the EPSDT program: emergency dental services and all other medically necessary dental services. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits. For eligible beneficiaries 21 years of age and older (non-EPSDT), an $1,800 annual benefit maximum applies, with the following exceptions: • Emergency dental services • Services including pregnancy-related services and for other conditions that might complicate the pregnancy. • Dentures • Dental implants and implant-retained prostheses.	Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). The Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization is required in general for crowns (except stainless steel crowns), root canal treatments, treatment of periodontal disease, dentures, implants, some complex oral surgical procedures, and orthodontic treatment. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

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

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

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

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

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance and acquisition of skills and audiology may be provided only upon the written prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. 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. Speech therapy and audiology services are covered in hospital outpatient departments and organized outpatient clinics for all Medi-Cal beneficiaries. Speech therapy and audiology services are covered under this state plan only for the following beneficiaries: 1. Pregnant women, if the speech therapy and audiology services are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnosis and Treatment Program.	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.

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

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

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

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

STATE PLAN CHART

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

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

STATE PLAN CHART

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

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

State Plan Chart

(Note: This chart is an overview only.)

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

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

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	See Supplement 2 to Attachment 3.1-B for program coverage and eligibility details.	Services are based on medical necessity and in accordance with a client plan signed by a licensed mental health professional. Beneficiaries must meet medical necessity criteria.
13.d.5 Substance Use Disorder Treatment Services	Substance use disorder treatment services include: Narcotic treatment program (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Naltrexone Treatment (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

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

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Outpatient Drug Free Treatment Services (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. In those cases where additional services are needed for EPSDT individuals under 21, these services are available subject to prior authorization. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Day care rehabilitative treatment services (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Perinatal Residential Substance Use Disorder Services (see Supplemental 1 To Attachment 3.1-B for program coverage and details under Extended Services For Pregnant Women)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. Room and board are not reimbursable DMC services.
	Substance Use Disorder Treatment Services Provided to Pregnant and Postpartum Women (see Supplemental 1 To Attachment 3.1-B for program coverage and details under Extended Services For Pregnant Women)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

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

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B

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

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

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

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

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."

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(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.

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

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	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.

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	TYPE OF SERVICES	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Extended services for pregnant women.	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	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.

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	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
23a.	Medical transportation services	Covered when transport by ordinary means is medically contraindicated and the transportation is required for covered medical care, subject to limitation. Only the lowest cost type of medical transportation adequate for the patient's needs is covered.	All nonemergency transportation requires prior authorization and a physician's, dentist's or podiatrist's written prescription. Emergency claims must be accompanied by justification.
23b.	Christian Science practitioners	Limited to the extent allowed under Title XVIII of the Social Security Act.	Services are subject to the two services per month limitation. See 6c.
23c.	Christian Science sanitoria care and services	See 4a.	See 4a.
23d.	SNF services provided for patients under 21 years of age	See 4a.	See 4a.
23d.1	Transitional Inpatient Care (TC) (Nursing Facility)	See 4a.3.	See 4a.3.
23e.	Emergency hospital services	See 1.	See 1.
23f.	Personal care services	Not covered.	

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STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services	LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus. LEA services are defined as: <u>Non-IEP/IFSP Assessments</u> • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.	<u>Service Limitations</u> LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student, • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management). All Medi-Cal recipients have access to enrolled LEA providers for the services they provide.

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STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.	Provider Qualifications Services must be performed by providers who meet the applicable qualification requirements as defined in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed speech-language pathologists (formerly credentialed language, speech and hearing specialists), credentialed audiologists (formerly credentialed language, speech and hearing specialists), licensed physical therapists, registered occupational therapists, and registered dieticians. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110. In addition, the following limitations apply: • Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.

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Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services (cont.)	Treatment Services • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 4(b) and 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); Medical transportation (as covered in Subsection 24(a).	• Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students. • Credentialed audiologists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of a licensed audiologist only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students.

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Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services (cont.)		• Credentialed speech-language pathologists who have a preliminary or professional clear services credential in speech-language pathology may provide assessments and treatment services related to speech, voice, language, or swallowing disorders, for which a student has been referred by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students. Credentialed speech-language pathologists who do not have a preliminary or professional clear services credential in speech-language pathology may provide services under the direction of a licensed speech-language pathologist or a credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology. The State's Attorney General, in opinion #06-1011, dated November 30, 2006, concluded that the State's qualifications for the professional clear credential and the preliminary credential for speech-language pathologists were equivalent to the federal speech-pathologists qualifications in 42 CFR 440.110. • Credentialed pupil service workers may provide psychosocial assessments only; • Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only; • School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

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Type of Service	Program Coverage**	Authorization and Other Requirements*
23g Local Education Agency (LEA) Services (cont.)		• The definition of "under the direction of" a licensed audiologist, licensed speech-language pathologist or credentialed speech-language pathologist who has a professional clear services credential in speech-language pathology is that the practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed practitioners that he or she agrees to direct. The practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

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

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. 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.

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TYPE OF SERVICE	PROGRAM COVERAGE*	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
28.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.
28.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; and certified nurse midwives; as licensed by the State.
	b.2 Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in an alternative birth center within the scope of practice under State law.	Certified nurse practitioners must be under the supervision of a physician and licensed by the State.

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