(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 #88 17

Eff 7-1-80

App MAR 2 1 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.

SPA #88-17

Eff 7-1-88

App MAR 21 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.
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(Note: This chart is an overview only.)

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

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** Coverage is limited to medically necessary services.

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR 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 when provided through Child Health and Disability Prevention Program.	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, and day care habilitation offered in local mental health clinics or in the community.	Medical necessity is the only limitation.
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	Physicians' services	As medically necessary, subject to limitations; however, experimental services are not covered. 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.)	Physician services to not require prior authorization except as noted below: Outpatient medical procedures such as hyperbaric O^2 therapy, psoriasis day care, apheresis, cardiac catheterization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.

* Prior authorization is not required for emergency service.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	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.
5b Medical and surgical services furnished by a dentist.	As required, with certain exceptions. Noncovered services include orthodontic services, cosmetic procedures, experimental procedures.	Dental services are currently provided through contract with Delta Dental Plans of California (DDPC). DDPC approves and provides payment for covered services. Prior authorization by DDPC is required on a limited basis for restorative dentistry and dentures, periodontal, endodontia services, and laboratory-processed crowns.
6 Medical care and any other type of remedial care recognized under State law.		
a. Podiatrists' 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.	Routine office visits do not require prior authorization. All other podiatry services are subject to prior authorization, except emergencies. All services provided in SNFs and ICFs are subject to prior authorization.

* Prior authorization is not required for emergency service.

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