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(Note: This chart is an overview only.)

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

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA #88-17 Eff 7-1-88 App

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.3	Acupuncture services	Covered to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition.	Same as 6c.
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		
7a 7b	Home health nursing and aide services	Covered when prescribed by a physician in the home of a beneficiary in accordance with a written treatment plan. The patient's condition must require skilled nursing care or other therapeutic services.	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 service.

** Coverage is limited to medically necessary services.

App MAR 2 1 1989

SPH-4 88-17

Eff 7-1-88

STAT 'LAN CHART

(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.	Prior authorization is required for supplies not listed in the Medical Supplies Formulary. Certain items require authorization unless used for the conditions specified in the Medical Supplies Formulary.
	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.	
	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 bank supplying the blood or facility where transfusion is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #88-17

Eff 7-1-88

App

(Note: This chart is an overview only.)

	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 the medical needs of the patient.
7c.3	Hearing aids	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.	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. Authorization for hearing aids may be granted only when tests reveal an average loss of 35 dB or greater, or if the difference between the level of 1,000 Hertz and 2,000 Hertz is 20 dB or more. The hearing loss need only be 30 dB, and speech communication is effectively improved or the need for personal safety is met.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH#88-17

Eff 7-1-88

App MAR 21 1989

STATI LAN CHART

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d	Physical and occupational therapy, speech pathology and audiology services provided by a home health agency	See 11.	See 11.
8	Special duty nursing services	Not covered.	
9	Clinic services	See 2a.	See 2a.
10	Dental services	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.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #88-17

Eff 7-1-88

App MAR 2 1

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11	Physical therapy and related services	Physical therapy and occupational therapy are covered only when prescribed by a physician, dentist, or podiatrist. Speech pathology and audiology may be provided only upon the written prescription of a physician or dentist. Outpatient physical therapy, occupational therapy, speech therapy, and audiology provided in a certified rehabilitation center are payable only when billed by the rehabilitation center. Maintenance therapy services are not covered.	All physical therapy services are subject to prior authorization. Occupational therapy, speech pathology, and audiology services rendered by independent practitioners are subject to the availability of MEDI labels, except that these services, when rendered to patients in SNFs or ICFs are subject to prior authorization. In a certified rehabilitation center, one visit in a six-month period for evaluation of the patient and preparation of an extended treatment plan may be provided without prior authorization. Additional services including other evaluations can be provided in accordance with an approved treatment plan signed by a physician, subject to prior authorization.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

App MAR 21 1989

SPA #88-17

Eff 7-1-88

(This chart is an overview only.)

	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.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b	Dentures	See 10.	See 10.
12c	Prosthetic and orthotic appliances	Covered when prescribed by a physician or podiatrist. Stock shoes (conventional or orthopedic) are covered when at least one of the shoes is to be attached to a prosthesis or brace. Orthopedic modifications to stock shoes are also covered.	Prior authorization is required when the purchase price is more than $100. Prior authorization is required for rental, or repair when the total cost is more than $50. Custom-made orthopedic shoes may be authorized when there is a clearly established medical need that cannot be satisfied by the modification of stock orthopedic shoes.
12d	Eyeglasses, prosthetic eyes, and other eye appliances	Covered as medically necessary on the written prescription of a physician or optometrist.	Prior authorization is required for some vision aids and contact lenses.
13a	Diagnostic services	See 4b	
13b	Screening services	See 4b	
13c	Preventive services	See 4b EPSDT program coverage. Covered services for pregnant/ postpartum Medi-Cal recipients etc.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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

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	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13d.1	Adult day health care	Covered when requested by a physician for elderly persons or other adults with mental or physical impairments which handicap daily living activities, require treatment, or rehabilitative services but which are not of such a serious nature as to require 24-hour nursing care.	Prior authorization is required. Requests for authorization must be accompanied by a multidisciplinary team assessment which ascertains the individual's pathological diagnosis, physical disabilities, functions, abilities, psychological status, and social and physical environment.
13d.2	Chronic dialysis services	Covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Home dialysis and continuous ambulatory peritoneal dialysis are covered.	Prior authorization is required for the facility but not the physician. Initial authorization may be granted up to three months. Reauthorization may be granted up to 12 months. Inpatient hospitalization for patients under going dialysis requires prior authorization.
13d.3	Outpatient heroin detoxification services.	Daily treatment is covered through the 21st day.	Prior authorization is required. Additional charges may be billed for services medically necessary to diagnose and treat diseases which the physician believes are concurrent with, but not part of, the outpatient heroin detoxification services.
13d.4	Rehabilitative mental health services for seriously emotionally disturbed children.	See 4b EPSDT program coverage.	Medical necessity is the only limitation.

* Prior authorization is not required for emergency service.

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

TN No. 91-26 Supercedes TN No. 88-17 Approval Date AUG 0 5 1992 Effective Date October 1, 1991

TYPE OF SERVICE	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
13d.4 Rehabilitative mental health services (Continued)	Short-Doyle/Medi-Cal rehabilitative mental health services are provided in the least restrictive setting appropriate for maximum reduction of psychiatric impairment, restoration of functioning consistent with requirements for learning and development, and/or independent living and enhanced self-sufficiency.	Services are based on medical necessity and in accordance with a coordinated client plan signed by a licensed practitioner of the healing arts.
13d.5 Alcohol and drug treatment services	Narcotic replacement therapy services, including outpatient methadone maintenance and/or levoalphacetylmethadol (LAAM) are covered under Drug Medi-Cal when prescribed by a physician as medically necessary to alleviate the symptoms of withdrawal from opiates.	Prior authorization is not required. Post-service periodic reviews are conducted by the Department of Alcohol and Drug Programs pursuant to an interagency agreement with the Department of Health Services, the single state agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Naltrexone provided as an outpatient treatment service directed at serving detoxified opiate addicts is covered under Drug Medi-Cal when prescribed by a physician as medically necessary. Pregnant clients are precluded from receiving these services.	Same as above.