STATE N CHART

(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 performed in a skilled nursing facility (SNF) or intermediate care facility (ICF).
4a	Skilled nursing facility	Covered when patient has need for daily skilled nursing and/or daily special rehabilitation services which, as a practical matter, can only be provided on an inpatient basis. The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	Prior authorization is required. Attending physicians must recertify a patient's level of care and plan every 60 days. For patients having Medicare as well as Medi-Cal eligibility (crossover cases), authorization is required at the time of Medicare denial or on or before the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH #88-17

Eff 7-1-88

App

STATE CHART

(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.

SPA 88-17

Eff 7-1-88

App

STATE P CHART

(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.

SPA # 88-17

Eff 9-1-88

App MAR 21 1989

STATE V CHART

(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 #188 17

Eff 7-1-80

App MAR 21 1989

STATE CHART

(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 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.