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.

	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.

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** 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*
		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.

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

STATE CHART

(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.

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(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.

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(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies	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 supplies not listed in the Medical Supplies Formulary. Certain items require authorization unless used 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 bank supplying the blood or facility where transfusion is given.

* Prior authorization is not required for emergency service.

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(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.

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(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.

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(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.

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	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.