(Note: This chart is an overview only.)

STA . PLAN CHART

	TYPE OF SERVICE	PROGRAM COVERAGE**	Limitations on Attachment 3.1-A 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.

TN No. 91-12 supersedes TN No. 88-17

(Note: his chart is an overview only.)

STAT' 'LAN CHART

	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.

	TYPE OF SERVICE	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
13d.5	Alcohol and drug treatment services (Continued)	Outpatient drug free services directed at stabilization and rehabilitation of patients who have a substance-related disorder diagnosis are covered under Drug Medi-Cal when prescribed by a physician as medically necessary. See Supplement 2 to Attachment 3.1-A for a description of alcohol and drug treatment services for pregnant and postpartum women.	Same as above, except in those cases where additional EPSDT services (beyond those available under Department of Alcohol and Drug Program regulations) are needed for individuals under 21, services are available subject to prior authorization by the Department of Health Services.
14a.	Services for individuals age 65 or older in institutions for tuberculosis	See 1, 4a, 15.	See 1, 4a, 15.
14b.	Services for individuals 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. Services are available equally to the categorically needy and medically needy.

STATE I CHART

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

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15	ICF services	Covered when patient is under the care of a physician and requires out-of-home protective 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's physician must recertify patient's need for continued care every 60 days.
15a	ICF services for the developmentally disabled, developmentally disabled habilitative, or developmentally disabled nursing	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's 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	See 1.	See 1.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPM #88-17

Eff 7-1-88 App MAR 2 1 1989

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 each of the four levels of hospice care described in regulation: routine home care, continuous home care, inpatient respite care, and general inpatient care. Special physicians services do not require prior authorization. Persons electing hospice care agree to waive their right to receive curative services related to their terminal illness.

* 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*
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.

(Note: This chart is an overview only.)

	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

(Note: This chart is an overview only.)

STATE PLAN CHART

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 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.