DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, Missouri 64106-2898

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

February 3, 2020

Mari Cantwell, Chief Deputy Director
Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0046, which was submitted to the Centers for Medicare & Medicaid Services on November 13, 2019. This SPA restores coverage for certain optional benefits such as optometric and opticians' services, audiology services, speech therapy services, podiatric services and incontinence creams and washes. The SPA also removes the monthly two-visit limit for services by podiatrists.

SPA #19-0046 was approved January 29, 2020, with an effective date of January 1, 2020, as requested by the state. Enclosed is a copy of the CMS 179 summary form, as well as the following approved SPA pages to be incorporated into your state plan:

- Limitations on Attachment 3.1-A and Attachment 3.1-B, pages 3b, 3d, 3e, 10b, 11, 12, 13, 15, 15a, 16a, 16b and 18a

- Supplement 6 to Attachment 4.19-B, pages 2 and 2a

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2020.02.03 13:28:57 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc:
Jacey Cooper, California Department of Health Care Services (DHCS)
Rene Mollow, DHCS
Cynthia Smiley, DHCS
Jim Elliott, DHCS
Raquel Sanchez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 0046

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.60, 440.70, and 440.120

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 8,133,000
b. FFY 2021 $ 10,844,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Limitations on Attachment 3.1-A and 3.1-B, pages 3b, 3d, 3e, 10b, 10c, 11, 12, 13, 15, 15a, 16a, 16b, 16c, and 18a
Supplement 6 to Attachment 4.19-B, pages 2 and 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Limitations on Attachment 3.1-A and 3.1-B, pages 3b, 3d, 3e, 10b, ~~10c,~~ 11, 12, 13, 15, 15a, 16a, 16b, ~~16c,~~ and 18a
Supplement 6 to Attachment 4.19-B, pages 2 and 2a

10. SUBJECT OF AMENDMENT
Restores full coverage for audiology services, speech therapy, podiatry, optometric and optician services, and incontinence creams and washes. Removes the monthly two-visit limit for podiatrist services.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
November 13, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
November 13, 2019

18. DATE APPROVED
January 29, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2020.02.03 13:31:37 -06'00'

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations, Medicaid and CHIP Operations Group

23. REMARKS
For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.
Box 9: Limitations on Att. 3.1-A/3.1-B, pages 10c and 16c no longer exist under the approved SPA due to the deletion of limitations language and the transfer of remaining content to pages 10b and 16b, respectively. So CMS has deleted the references to 10c and 16c in this box with the state's permission in email dated 1/24/20.

Instructions on Back

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan (continued).	9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license. 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	

*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*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license. 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license. 6. Comprehensive Perinatal Services Program (CPSP) practitioner services. 7. Licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license. 8. Clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license. 9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license. 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license.	

* 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*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
	FQHC home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

*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*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatry	Services by podiatrists are covered benefits when furnished within their scope of practice in accordance with California state law. 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.	All services provided in SNFs and ICFs are subject to prior authorization.

*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*
6c. Chiropractic	Services by chiropractors are covered when furnished within their scope of practice in accordance with California state law. Chiropractic services are limited to manual manipulation of the spine. This is a covered benefit only for the following beneficiaries: 1. Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit. Chiropractic services are covered in Federally Qualified Health Centers and Rural Health Clinics for all beneficiaries.	
	Outpatient chiropractic services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, occupational therapy, and speech therapy.	TAR is required for a chiropractic service visit that exceeds the two-visit limit.

*Prior authorization is not required for emergency services.
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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.3 Acupuncture	Services by acupuncturists are covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition when furnished within their scope of practice in accordance with California state law.	
	Outpatient acupuncture services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: audiology, chiropractic, occupational therapy, and speech therapy.	TAR is required for an acupuncture service visit that exceeds the two-visit limit.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

(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 physician within the scope of his/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 certain items and for items not 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 banks supplying the blood or facility where transfusion is given.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d. Physical and occupational therapy, speech therapy, and audiology services provided by a home health agency.	See 11. The two-visit limit does not apply to therapies provided in the home health setting.	See 11.
8. Special duty nursing services.	Not covered.	
9. Clinic services	Clinic services are covered under this state plan. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include outpatient heroin or other opioid detoxification services. Services shall be furnished at the clinic by or under the direction of a physician or dentist. Chiropractic services are a covered benefit only for the following beneficiaries: • Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit.	Refer to appropriate service section for prior authorization requirements. Narcotic Treatment Programs pursuant to federal and state regulations are the only facilities that may administer methadone for heroin or other opioid detoxification services. Other narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Refer to type of service “5a Physician Services” for prior authorization and other requirements for outpatient heroin or other opioid detoxification services.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
9. Clinic services (continued)	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
10. Dental services	Effective January 1, 2018, pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, based on medical necessity and subject to limitations contained in applicable state statutes, regulations, manual of criteria, and utilization controls. For beneficiaries 21 years of age and older, there is an $1,800 annual benefit maximum, unless medically necessary or under the following exception: • Emergency dental services • Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and for other conditions that might complicate the pregnancy • Dentures • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses • Services provided in long-term care facilities For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Ace (42 U.S.C. Sections 1396d(a)(4)(B) and (r)), early and periodic screening, diagnostic, and treatment services are covered. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not covered benefits.	Dental services are administered through an agreement between the Medi-Cal Dental program and its contractor(s). On behalf of the State, the Dental contractor(s) shall approve and provide payment for covered dental services performed by an enrolled dental provider when services are provided in accordance with the State's manual of criteria.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11b. Occupational Therapy	Occupational therapy is covered for the restoration, maintenance, and acquisition of skills only when prescribed by a physician, dentist, or podiatrist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Outpatient occupational therapy provided in a certified rehabilitation center is covered only when billed by the rehabilitation center.	Services must be performed by providers who meet the applicable qualification requirements as defined for occupational therapy in 42 CFR Section 440.110(b), licensed and within their scope of practice under state law.
	In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	More than one evaluation visit in a six-month period requires authorization.
	Outpatient occupational therapy services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: acupuncture, audiology, chiropractic, and speech therapy.	TAR is required for an occupational therapy visit that exceeds the two-visit limit.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance, and acquisition of skills and audiology may be provided only upon the prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Speech therapy and audiology provided in a certified rehabilitation center is covered only when billed by the rehabilitation center. In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization. Outpatient speech therapy and audiology services are limited to a maximum of two services in any one calendar month or any combination of two services per month from among the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, chiropractic, and occupational therapy.	Services must be performed by providers who meet the applicable qualification requirements as defined for speech therapy and audiology services in 42 CFR Section 440.110(c), licensed and within their scope of practice under state law. More than one evaluation visit in a six-month period requires authorization. TAR is required for a speech therapy or audiology visit that exceeds the two-visit limit.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the prescription of a physician or optometrist.	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of glasses. Prior authorization is required for ophthalmic lenses and specialty frames that cannot be supplied by the fabricating optical laboratory.
13a. Diagnostic Services	Covered under this state plan only for the EPSDT benefit.	
13b. Screening Services	Covered under this state plan only for the EPSDT benefit.	
13c. Preventive Services	Includes, at a minimum, a broad range of preventive services including “A” or “B” services recommended by the United States Preventive Services Task Force (USPSTF); Advisory Committee on Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration’s (HRSA) Bright Futures program/project; and additional preventive services for women as recommended by the Institute of Medicine (IOM). Services are provided and covered by a physician or other licensed practitioner within the scope of his or her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services. The State assures that the benefit package will be updated as changes are made to USPSTF, ACIP, and IOM recommendations, and that the State will update coverage and billing codes to comply with these revisions.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan (continued).	9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license. 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
	FQHC home nursing services are provided only to established patients of the center to ensure continuity of care. Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Refer to home health services section for additional requirements.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatry	Services by podiatrists are covered benefits when furnished within their scope of practice in accordance with California state law. 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.	All services provided in SNFs and ICFs are subject to prior authorization.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6c. Chiropractic	Services by chiropractors are covered when furnished within their scope of practice in accordance with California state law. Chiropractic services are limited to manual manipulation of the spine. This is a covered benefit only for the following beneficiaries: 1. Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. 2. Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit. Chiropractic services are covered in Federally Qualified Health Centers and Rural Health Clinics for all beneficiaries.	
	Outpatient chiropractic services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, occupational therapy, and speech therapy.	TAR is required for a chiropractic service visit that exceeds the two-visit limit.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d.3 Acupuncture	Services by acupuncturists are covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition when furnished within their scope of practice in accordance with California state law.	
	Outpatient acupuncture services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: audiology, chiropractic, occupational therapy, and speech therapy.	TAR is required for an acupuncture service visit that exceeds the two-visit limit.

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**Coverage is limited to medically necessary services.

(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 physician within the scope of his/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 certain items and for items not 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 banks supplying the blood or facility where transfusion is given.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d. Physical and occupational therapy, speech therapy, and audiology services provided by a home health agency.	See 11. The two-visit limit does not apply to therapies provided in the home health setting.	See 11.
8. Special duty nursing services.	Not covered.	
9. Clinic services	Clinic services are covered under this state plan. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include outpatient heroin or other opioid detoxification services. Services shall be furnished at the clinic by or under the direction of a physician or dentist. Chiropractic services are a covered benefit only for the following beneficiaries: • Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit.	Refer to appropriate service section for prior authorization requirements. Narcotic Treatment Programs pursuant to federal and state regulations are the only facilities that may administer methadone for heroin or other opioid detoxification services. Other narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Refer to type of service “5a Physician Services” for prior authorization and other requirements for outpatient heroin or other opioid detoxification services.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
9. Clinic services (continued)	The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity through the TAR process: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	
10. Dental services	Effective January 1, 2018, pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, based on medical necessity and subject to limitations contained in applicable state statutes, regulations, manual of criteria, and utilization controls. For beneficiaries 21 years of age and older, there is an $1,800 annual benefit maximum, unless medically necessary or under the following exception: • Emergency dental services • Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and for other conditions that might complicate the pregnancy • Dentures • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses • Services provided in long-term care facilities For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Ace (42 U.S.C. Sections 1396d(a)(4)(B) and (r)), early and periodic screening, diagnostic, and treatment services are covered. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not covered benefits.	Dental services are administered through an agreement between the Medi-Cal Dental program and its contractor(s). On behalf of the State, the Dental contractor(s) shall approve and provide payment for covered dental services performed by an enrolled dental provider when services are provided in accordance with the State's manual of criteria.

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**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11b. Occupational Therapy	Occupational therapy is covered for the restoration, maintenance, and acquisition of skills only when prescribed by a physician, dentist, or podiatrist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Outpatient occupational therapy provided in a certified rehabilitation center is covered only when billed by the rehabilitation center.	Services must be performed by providers who meet the applicable qualification requirements as defined for occupational therapy in 42 CFR Section 440.110(b), licensed and within their scope of practice under state law.
	In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization.	More than one evaluation visit in a six-month period requires authorization.
	Outpatient occupational therapy services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based upon medical necessity through the TAR process: acupuncture, audiology, chiropractic, and speech therapy.	TAR is required for an occupational therapy visit that exceeds the two-visit limit.

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**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11c. Speech Therapy/Audiology	Speech therapy for the restoration, maintenance, and acquisition of skills and audiology may be provided only upon the prescription of a physician or dentist. Prescriptions for treatment plans are limited to six months and may be renewed for medical necessity. Speech therapy and audiology provided in a certified rehabilitation center is covered only when billed by the rehabilitation center. In a certified rehabilitation center, one visit in a six-month period to evaluate the patient and prepare an extended treatment plan may be provided without authorization. Outpatient speech therapy and audiology services are limited to a maximum of two services in any one calendar month or any combination of two services per month from among the following services, although additional services can be provided based on medical necessity through the TAR process: acupuncture, chiropractic, and occupational therapy.	Services must be performed by providers who meet the applicable qualification requirements as defined for speech therapy and audiology services in 42 CFR Section 440.110(c), licensed and within their scope of practice under state law. More than one evaluation visit in a six-month period requires authorization. TAR is required for a speech therapy or audiology visit that exceeds the two-visit limit.

*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*
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the prescription of a physician or optometrist.	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of glasses. Prior authorization is required for ophthalmic lenses and specialty frames that cannot be supplied by the fabricating optical laboratory.
13a. Diagnostic Services	Covered under this state plan only for the EPSDT benefit.	
13b. Screening Services	Covered under this state plan only for the EPSDT benefit.	
13c. Preventive Services	Includes, at a minimum, a broad range of preventive services including “A” or “B” services recommended by the United States Preventive Services Task Force (USPSTF); Advisory Committee on Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration’s (HRSA) Bright Futures program/project; and additional preventive services for women as recommended by the Institute of Medicine (IOM). Services are provided and covered by a physician or other licensed practitioner within the scope of his or her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services. The State assures that the benefit package will be updated as changes are made to USPSTF, ACIP, and IOM recommendations, and that the State will update coverage and billing codes to comply with these revisions.

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

REIMBURSEMENT FOR INDIAN HEALTH SERVICES
AND TRIBAL 638 HEALTH FACILITIES

A. Below is a list of health professionals that may bill under the IHS all-inclusive rate:

- Physician
- Physician Assistant
- Nurse Practitioner
- Nurse Midwife
- Registered Dental Hygienist
- Registered Dental Hygienist in Extended Functions
- Registered Dental Hygienist in Alternative Practice
- Clinical Psychologist
- Clinical Social Worker
- Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Acupuncturist
- Visiting Nurse, if services are provided in the Tribal facilities
- Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the services of Licensed Marriage, Family, and Child Counselors are available as “other health visit” to persons under 21 years of age, as a result of an EPSDT screening which identifies the need for a service which is necessary to correct or ameliorate a mental illness or condition.

B. Comprehensive Perinatal Service Program providers who are licensed and/or certified practitioners who are able to render covered services in accordance with their scope of practice as identified in California statute. A September 17, 1985, HCPA letter allows these services as a physician or clinic service.

C. In addition, below is a list of associates and interns that may provide Medi-Cal psychology services:

- Associate Marriage and Family Therapist
- Associate Professional Clinical Counselor
- Associate Clinical Social Worker
- Psychological Assistant

Associates and assistants must be under the supervision of a licensed mental health professional, in accordance with their scope of practice and applicable state laws.

D. Except for the services specified under Item E below, the following other ambulatory services, but not limited to, provided by health professionals can be billed under the IHS all-inclusive rate.

- Acupuncture
- Medical and surgical services provided by a doctor of dental medicine or dental surgery which, if provided by a physician, would be considered physician services
- Physical Therapy
- Occupational Therapy
- Podiatry
- Drug and alcohol visits (subject to Medi-Cal provider participation requirements)
- Telemedicine and teledentistry (no additional live transmission costs will be reimbursed)
- Optometry

E. Chiropractic services are covered only for the following beneficiaries:

- Pregnant women, if the chiropractic service is part of their pregnancy-related services or services for a condition that might complicate the pregnancy.
- Individuals who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit.