

**MANUAL OF CRITERIA  
FOR  
MEDI-CAL AUTHORIZATION**

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## INTRODUCTION

This document is a compilation of criteria which apply to some services provided under the Medi-Cal program, California's version of the Medicaid program, Title XIX of the Social Security Act.

The Department of Health Services has established requirements in its regulations governing the Medi-Cal program which require that certain services can be paid for under Medi-Cal only after those services are authorized by a consultant working for the Department. These requirements are designed to ensure that program funds are spent on services that are medically necessary. The criteria published in this manual, while not exhausting the range of services covered by Medi-Cal, will nonetheless help to standardize consultants' exercise of professional judgment. Indeed, the criteria themselves have been developed by medical professionals who are fully aware of the vast range of medical and health care problems that patients encounter.

While this manual contains some information on Treatment Authorization Requests (TARs), it is not an instruction guide in the proper completion of TARs. We suggest that providers with questions on completing TARs refer to the Provider Manual distributed by the fiscal intermediary for the Medi-Cal program, or contact the nearest Field Services Branch office.

Chapter 1411 of the Statutes of 1985, mandated the Department's definition of medical necessity or medically necessary services to be those services reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

If the clinical condition of the patient meets the definition of medical necessity, the proposed treatment meets objective medical criteria, and is not contraindicated, and such information is adequately documented on the TAR, the consultant shall grant authorization if in his/her professional judgment the service request is both reasonable in cost and consistent with the medical needs of the patient. For the purposes of TAR review, "contraindicated" includes, but is not limited to, services which are duplicative, potentially harmful, or not within the usual standard of care.

## **REGULATORY/STATUTORY AUTHORITY**

This "Manual of Criteria for Medi-Cal Authorization" is incorporated, by reference, into the state regulations governing the Medi-Cal program in Title 22, California Code of Regulations (CCR), Section 51003.

Section 51003, in turn, implements various provisions of state law; specifically, Sections 14053, 14132, 14133, 14133.1, 14133.25, and 14133.3 of the Welfare and Institutions Code (W&I) Code. The Department of Health Services has enacted Section 51003 under the authority granted by the Legislature in Section 14105 and 14124.5 and 17025 of the Welfare and Institutions Code, and Section 57(c) of Chapter 328 of the Statutes of 1982.

**STATEMENT OF DEPARTMENT OF HEALTH SERVICES' INTENT*****Purpose***

These criteria are intended to:

1. Assist Medi-Cal consultants' review of requests for services or items requiring prior authorization;
2. Promote more uniform and consistent review of requests for services among the consultants in the various Medi-Cal field offices as well as among the consultants within a Medi-Cal field office;
3. Assist providers in requesting authorization and documenting the need for such services and items;
4. Improve the quality of care and cost efficiency of health services given to patients;
5. Avoid provision of unnecessary or excessive items or services to patients;
6. Promote objectivity and uniformity in appropriate treatment of medical conditions.

Information necessary for approval of Treatment Authorization Requests (TARs):

***General Information Requirements***

The diagnosis and specific items or services, with procedure codes, as appropriate, to be provided are required in every case.

Additional information which the provider should submit, or which the Medi-Cal consultant may request, include the following, as appropriate to the service being requested:

1. Chief complaint.
2. Relevant past medical/psychiatric history, including previous episodes and treatment of present illness, hospitalizations, dates, and duration.
3. History of present illness and date of onset, where the duration and severity of the patient's condition for the present and foreseeable future is important to establish the need for the particular service requested.
4. Significant associated diagnoses.
5. Limitations of function due to illness, when the service requested is related to a functional limitation or where such information would help establish the need for the requested service.
6. Treatment plan and expected duration, where the requested service is one that requires a treatment plan or where the services are to be continuous, frequent, or periodic over an extended period.

7. Drug regimen, where the drugs taken by the patient affect any of the above items (e.g., functional limitations).
8. Specific goal of therapy, where appropriate.
9. Prognosis.
10. Progress report since last TAR, if services requested are an extension or repeat of earlier services provided.

***Specific Information Requirements***

Other clinical data supportive of specific procedures are listed under the particular procedure.

***Note***

If the TAR form provides inadequate space, another sheet of paper should be attached.

Without sufficient information, the consultant has no option but to deny approval or defer a decision. The necessity for the consultant to obtain adequate information and thereby to make a judgment on medical necessity is an integral part of treatment authorization scheme.

**CRITERIA FOR EMERGENCY AND PREGNANCY-RELATED SERVICES  
FOR PERSONS ENTITLED TO RESTRICTED BENEFITS ONLY**

The following criteria are presented to clarify the provisions contained in Section 14007.5 of the Welfare and Institutions Code and in related State and federal laws. The approach adopted in these criteria is to set forth the parameters of what constitutes an emergency medical condition, and have these parameters applied to the circumstances of individual cases based on the medical judgment of professionals capable of applying them. These criteria do not spell out every condition and circumstance under which services provided to an individual covered under this provision would end. To attempt to do so would constrain the exercise of medical judgment by trained professionals.

Accordingly, each Treatment Authorization Request (TAR) will be evaluated on the documentation presented after emergency services are rendered, applying the guidance set forth in the criteria. These criteria make no changes in existing TAR procedures.

Pursuant to provisions of state and federal law, undocumented aliens and specified classes of amnesty aliens are eligible for restricted benefits only. Aliens entitled to restricted benefits have Medi-Cal cards with the appropriate restricted aid code.

Depending on the alien's status, restricted benefits may include (1) care and services that are necessary for the treatment of an emergency medical condition (including renal dialysis services, but not related to an organ transplant procedure) and medical care directly related to the emergency, as defined in federal law, and (2) long term care. Acute, ongoing, and maintenance renal dialysis services are covered as emergency services. These criteria make no changes in the scope of renal dialysis services previously available.

The following criteria apply only to emergency services and pregnancy-related services.

**I. Emergency and Pregnancy-Related Services**

Any alien who is otherwise eligible for Medi-Cal services, and who is not a lawful permanent resident or permanently residing in the United States under color of law (PRUCOL), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition (not related to any organ transplant procedure but including renal dialysis services and emergency labor and delivery) and medical care directly related to the emergency, as defined in federal law, and for medically necessary pregnancy-related services.

For purposes of applying these criteria, "medical care directly related to the emergency" includes only such care and services that are necessary for the treatment of an emergency medical condition as defined in paragraphs I.A and I.B below.



**A. Definition in Federal Statute (42 U.S.C. Section 1306b (v))**

The term "emergency medical condition" is defined in federal statute to mean a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

**B. Definition in Federal Regulations (42 C.F.R. Section 440.255)**

"Emergency medical condition" is defined in federal regulations to mean that the alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**C. Additional Criteria and Interpretative Guidelines**

1. Services provided to aliens must be medically necessary. Medically necessary services are those services which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
2. Medi-Cal includes as a benefit to an otherwise eligible alien care and services necessary for the treatment of the emergency medical condition and medical care directly related to the emergency, as defined in federal law. That is, Medi-Cal coverage for individuals whose eligibility is limited to emergency services begins at the point described in paragraph A above and ends when the patient is stabilized so that the conditions described in paragraphs I.A and I.B no longer apply.

3. If an eligible individual receives treatment for an emergency medical condition and continues to receive care after the emergency ends (that is, when the conditions described in paragraphs I.A and I.B no longer exist), treatment after the emergency ends is not covered by Medi-Cal.
4. Medi-Cal coverage is available for care and services necessary for the treatment of the emergency medical condition and medical care directly related to the emergency, as defined in federal law. Medi-Cal coverage is not available for continuing or follow-up care that may be necessary to restore the patient to health.
5. The federal definition (set forth in paragraphs I.A and I.B) defines an emergency medical condition. Without implying any limitation on the definitions in paragraphs I.A and I.B, the terms "acute," "sufficient severity," and "immediate medical attention" help to define the parameters within which Medi-Cal can cover services for the treatment of emergency medical conditions.

#### D. Pregnancy-Related Medical Services

Medi-Cal coverage for pregnancy-related services is available to all aliens who meet all other Medi-Cal eligibility requirements. Routine prenatal care, labor and delivery, routine post-partum care, and family planning are classified as pregnancy-related services. Medi-Cal also covers the treatment of conditions which complicate the pregnancy or delivery (such as hypertension, diabetes, and urinary tract infection).

Routine post-partum care extends for the 60-day period beginning on the last day of the pregnancy and ending on the last day of the month in which the 60th day occurs. All Medi-Cal family planning services are available to recipients of restricted benefits. All services would still need to meet the criteria of medical necessity.

#### II. Continuing Care/Follow-Up Care

Care and services that are necessary for the treatment of the emergency medical condition and medical care directly related to the emergency, as defined in federal law, are covered. "Medical care directly related to the emergency" includes only such care and services that are necessary for the treatment of an emergency medical condition as defined in paragraphs I.A and I.B above.

Accordingly, continuation of medically necessary inpatient hospital services and follow-up care after the emergency has resolved shall not be authorized or reimbursed for aliens eligible for restricted benefits only. This means that treatment aimed at a cure or long-term solution to the problem, such as transplantation or elective surgery, related to the underlying chronic condition shall not be authorized or reimbursed by the Medi-Cal program.

**CRITERIA MANUAL CHAPTER 5.0**  
**CRITERIA FOR HOSPITAL SERVICES (INPATIENT)**

**CRITERIA MANUAL CHAPTER 5.1****COMMON MEDICAL DIAGNOSES OR SURGICAL PROCEDURES**

Criteria for hospital services for specific common medical diagnoses and surgical procedures are presented in the following format. Procedures or diagnoses are grouped by organ systems (systems identified in the California Standard Nomenclature) and arranged alphabetically within each major grouping.

**Model Format and General Criteria****I. Clinical Information**

Clinical information must be supportive of each diagnosis and must indicate that the requested services are medically necessary. Medically necessary services are defined as those services reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain.

**II. Documentation**

Lists the minimally required medical information specific to the particular diagnosis or surgical procedure which must be present on the TAR for consideration for approval. In cases where other information is clearly conclusive, the medical consultant may waive the absence of the documentation items. Approval will not be given unless the service is medically necessary.

**III. Initial Length of Stay**

The number of days that a patient with a given disorder customarily requires acute hospital care (may be less or more according to individual circumstances and may be extended if medically necessary).

**IV. Extension**

Justification for extension of stays beyond the days initially allowed must be documented by the attending physician and entered in the patient's clinical record.

**A. General reasons for extension of initial stay common to all disorders are.**

1. Continuation of conditions originally necessitating admission.
2. Serious adverse reactions to drugs, procedures, or therapies.

3. Wound infection, separation, hemorrhage.
  4. Need for continuous intravenous or other parenteral fluids or medications.
  5. Pain requiring parenteral controlled substances.
  6. Fever over 100 degrees F (37.8 degrees C), unless expected with the condition.
  7. Pulmonary complications-pneumonia, atelectasis, respiratory insufficiency, pneumothorax.
  8. Cardiovascular complications-congestive failure, pulmonary embolism, acute myocardial infarction, severe arrhythmia.
  9. Urinary complications-retention, infection.
  10. Gastrointestinal complications-ileus, bowel obstruction, uncontrolled vomiting, or diarrhea.
  11. Neurological complications-impaired consciousness, loss of neuromuscular control.
  12. Injury or failure of any major organ system.
- B. Specific conditions and complications experienced with the disorder under treatment.

**INTEGUMENTARY**

**Pilonidal Cyst--Sinus Excision**

*Pilonidal Cyst–Sinus Excision*

I. Clinical Information

A. Signs and Symptoms

Pain, swelling, and drainage at lumbar dimple area with findings of:

1. Pilonidal cyst and sinus with
2. Chronic drainage, and/or
3. Recurrent infection, which is not responsive to trials of appropriate medical therapy (sitz baths, antibiotics, local incision, and drainage).

B. Laboratory Studies

1. Anoscopy.
2. Proctosigmoidoscopy (if clinically indicated).

II. Documentation

A. Pertinent Clinical Findings

1. Description of the pilonidal cyst and sinus with data indicating chronic, recurrent infection, and drainage, and
2. Duration and type of medical therapy trials.

B. Pertinent Laboratory Findings

Findings from anoscopy.

III. Initial Length-of-Stay

Three days.

IV. Extension

A. General

B. Specific

Dead space infection.



**MUSCULOSKELETAL**

**Hip Arthroplasty (Hip Prosthesis)  
Lumbar Disc Surgery  
Meniscectomy  
Shoulder Dislocation, Recurrent—Surgery**

**Hip Arthroplasty (Hip Prosthesis)****I. Clinical Information****A. Signs and Symptoms**

Pain and/or swelling, limitation of motion, and possible deformity of the hip area with findings indicating the following conditions:

1. Fresh fractures of the femoral neck in the older age group, senile, or patients otherwise judged not appropriate for internal fixation, or
2. Established nonunion of femoral neck, when osteotomy and/or grafting are contraindicated by age, personality factors, or avascular changes of bone, or
3. Avascular necrosis of the femoral head, or
4. Severe disabling pain and severe limitation of motion and ambulation due to rheumatoid or osteoarthritis which is not responsive to physical therapy and/or other medical treatment(s).

**B. Laboratory Studies**

X-ray views of the hip joint.

**II. Documentation****A. Pertinent Clinical Findings**

Selected cases as noted above with:

1. Fresh fracture of the femoral neck, and reasons given why patient is not suitable for internal fixation.
2. Established nonunion of femoral neck, and reasons given why patient is not suitable for osteotomy and/or grafting.
3. Evidence of avascular necrosis of the femoral head.
4. Findings concerning severe disabling pain and severe limitation of motion and ambulation due to rheumatoid or osteoarthritis; and description of type, duration, and degree of response to physical therapy and/or other medical treatment(s).

**B. Pertinent Laboratory Findings**

Copy of a recent X-ray report of positive hip joint(s) findings.

**III. Initial Length of Stay**

Thirteen days, with an additional seven days in a skilled nursing facility (SNF), if medically necessary.

**IV. Extension**

**A. General**

**B. Specific**

1. Displacement of prosthesis after initial insertion.
2. Wound infection.
3. Phlebothrombosis.
4. Pulmonary embolus.
5. Decubitus.

## **Lumbar Disc Surgery**

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. **Chronic and/or recurrent severe low back pain with possible nerve root type pain in the leg(s), with**
2. **Sensory dysesthesia frequent along the nerve root distribution, and possible**
3. **Weakness of the lower extremity of nerve root type (frequently weakness of dorsiflexion of foot and/or great toe) with**
4. **Decreased lower extremity deep tendon reflexes, and**
5. **Positive straight leg raising tests.**

#### **B. Laboratory Studies**

1. **X-ray of spine.**
2. **CT scan of spine.**
3. **Myelogram.**
4. **Electromyography.**
5. **H-reflex test.**

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

1. **Adequate history must include specific reference to:**
  - a. **When, how, and where symptoms began and/or recurred.**
  - b. **Degree of backache, pain, area involved, and aggravating factors.**
  - c. **Degree of weakness of parts and as regards persistence and/or progression.**
  - d. **Type and extent of sphincter involvement, if present.**
  - e. **Initial and chronic states of the condition must document failure of nonoperative treatment (bed rest, traction, physical therapy, or brace).**

2. Adequate physical examination must include specific reference to:

- a. Objective signs of backache, e.g., spasm, limited range of motion, pain on what motion.
- b. Description of any sensory loss.
- c. Description of any motor loss.
- d. Description of any deep tendon reflex changes.
- e. Results of recumbent leg sign tests (Lasegue, straight leg raising, etc.).

B. Pertinent Laboratory Findings

1. Positive results indicating presence of probably herniated disc from:

- a. CT scan or
- b. Myelogram.

2. Positive additional data in evaluation as clinically indicated as from:

- a. Electromyogram.
- b. H-reflex test.

III. Initial Length of Stay

- A. Laminectomy without fusion—8 days.
- B. Laminectomy with fusion—12 days.

IV. Extension

- A. General
- B. Specific

1. Persistent spinal fluid drainage.
2. New nerve damage with dysfunction.

**Meniscectomy****I. Clinical Information****A. Signs and Symptoms****1. Acute.**

- a. Knee pain with
- b. Hemarthrosis and
- c. Irreducible locked knee position (Usually indicates a bucket handle tear of medial semilunar cartilage).

**2. Chronic.**

- a. Complaint of "giving way" of knee joint with
- b. Knee joint locking episodes and
- c. Repeated effusion or hemarthrosis with
- d. Knee pain (from femur-tibial grinding) with
- e. Tenderness along the medial or lateral joint line and
- f. Terminal limitation of extension and/or flexion of the knee joint may be noted and
- g. Possible quadriceps atrophy.

**B. Laboratory Studies**

1. X-ray--knee joint.
2. Arthroscopy (may be planned as an inpatient procedure, preceding arthrotomy).

**II. Documentation****A. Pertinent Clinical Findings**

1. Information must indicate knee joint dysfunction as by:
  - a. Chronic and recurrent nature and
  - b. "Giving way" of knee joint and

- c. Knee joint locking episodes and
  - d. Knee joint effusion/hemarthrosis episodes and
  - e. Knee pain.
  - f. Tenderness along medial or lateral joint line may be noted.
  - g. Terminal limitation of extension and/or flexion of the knee joint may be noted.
  - h. Quadriceps atrophy may be noted.
2. Surgery to be considered only after evidence of failure of an adequate trial of conservative therapy such as:
- a. Protected weight bearing.
  - b. Quadriceps strengthening exercises.
  - c. Casts as required.
  - d. Aspiration of any effusion.

**B. Pertinent Laboratory Findings**

Positive information from clinically indicated studies such as:

- 1. X-ray—knee joint.
- 2. Arthroscopy.

**III. Initial Length of Stay**

Three days.

**IV. Extension**

**A. General**

**B. Specific**

- 1. Excessive joint effusion.
- 2. Hemarthrosis.

**Shoulder Dislocation, Recurrent--Surgery****I. Clinical Information****A. Signs and Symptoms**

1. Shoulder pain, deformity, and limitation of motion, with
2. History of three or more dislocations of the shoulder.
3. Evidence on examination of shoulder joint instability (plication of the capsule and/or anterior shoulder musculature).

**B. Laboratory Studies**

X-ray of shoulder joint.

**II. Documentation****A. Pertinent Clinical Findings**

Information must indicate evidence of:

1. Recurrent shoulder dislocation problem with:
  - a. Three or more documented episodes of shoulder dislocation by history with dates and places of treatment.
2. On examination, findings of:
  - a. Evidence of shoulder joint instability, as by plication of the capsule and/or anterior shoulder musculature, may occur, and
  - b. Shoulder may dislocate with abduction and external rotation.

**B. Pertinent Laboratory Findings**

Positive information from X-ray of shoulder joint.

**III. Initial Length of Stay**

Four days.

**IV. Extension****A. General****B. Specific**

Hemarthrosis.



**RESPIRATORY**

**Laryngectomy and Hemilaryngectomy**

## ***Laryngectomy and Hemilaryngectomy***

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. Chronic hoarseness with evidence of,
  - a. Positive diagnosis of carcinoma or
  - b. Significant airway obstruction, dysphagia, and/or odynophagia and
2. Chronic Laryngeal obstruction in which hemilaryngectomy may be a corrective procedure as in:
  - a. Bilateral vocal cord paralysis.
  - b. Traumatic lesions of the larynx or
  - c. Papilloma of the vocal cord area.

#### **B. Laboratory Studies**

1. Complete otolaryngological examination.
2. Endoscopy.
3. Laryngogram.
4. Pathological tissue examination.
5. Speech pathology consultation.

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

1. Information indicating a positive diagnosis of carcinoma of the larynx, or
2. Information indicating *significant* airway obstruction, and/or dysphagia due to:
  - a. Bilateral vocal cord paralysis.
  - b. Traumatic lesions of the larynx.
  - c. Papilloma of the vocal cord area.
  - d. Laryngological examination findings.

**B. Pertinent Laboratory Findings**

1. Endoscopy.
2. Laryngogram.
3. Pathological tissue exam report.

**III. Initial Length of Stay**

- A. Hemilaryngectomy--four days.
- B. Laryngectomy--12 days.

**IV. Extension**

**A. General**

**B. Specific**

1. Esophageal fistula.
2. Wound infection.
3. Persistent tracheal crusting.
4. Secondary pulmonary infection.
5. Psychogenic complications secondary to losing larynx and voice.

**MEDIASTINUM/DIAPHRAGM**

**Mammoplasty—Postmastectomy  
Mammoplasty--Reduction  
Mastectomy (Includes Lumpectomy and Excisional Biopsy)**

**5.1.15**

***Mammoplasty-Postmastectomy-This is Generally Excluded From Coverage.***

**Mammoplasty--Reduction**

**I. Clinical Information**

**A. Signs and Symptoms**

1. Extremely large pendulous breasts which when dependent extend down to at least the level of the antecubital fossae and
2. Breasts are so large and heavy that they cause frequent backache and
3. Supporting bra straps cut into the skin of the shoulders, with possible subcutaneous fat necrosis.
4. Chronic, unresponsive, breast intertrigo.
5. Significant interference with activities of daily living.
6. If significantly obese, evidence that weight reduction has not, or would not, reduce the above described symptoms.

**B. Laboratory Studies**

None

**II. Documentation**

**A. Pertinent Clinical Findings**

History and physical examination information must include:

1. Photos--frontal and profile views showing the dependent position of the breasts relative to the antecubital fossae.
2. Evidence that the large breasts cause constant discomfort such as backache and bra strap pressure.
3. If other symptoms are described, document the nature of the incapacity.
4. If significantly obese, history must show that weight reduction has not relieved or would not relieve the above symptoms.

**B. Pertinent Laboratory Findings**

Not applicable

**III. Initial Length of Stay**

Five days.

**IV. Extension**

**A. General**

**B. Specific**

1. Hematoma formation.
2. Dehiscence of suture lines.
3. Nipple transfer required.

***Mastectomy (Includes Lumpectomy and Excision/ Biopsy)***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Breast malignancy as evidenced by:
  - a. Palpable mass in the breast and may show
  - b. Skin retraction overlying the lesion and
  - c. Bloody or clear discharge from the nipple and at times
  - d. Palpable axillary and/or supraclavicular lymph nodes.
2. Chronic, recurrent, severe fibrocystic mastitis.

**B. Laboratory Studies**

1. Biopsy—needle aspiration.
2. Mammography.
3. X-ray—skeletal survey.
4. Bone scan.
5. Thermogram.
6. Pathological examination of tissue.
7. Tissue estrogen receptor site test.
8. Brain or CT scan.
9. Liver scan.

**II. Documentation**

**A. Pertinent Clinical Information**



1. Data indicating breast malignancy such as:
  - a. Size and location of palpable mass in the breast and may have
  - b. Skin retraction overlying the lesion and
  - c. Bloody discharge from the nipple and at times
  - d. Palpable axillary and/or supraclavicular nodes.
2. Evidence of fibrocystic mastitis which is:
  - a. Chronic and
  - b. Recurrently symptomatic regarding pain and tenderness.

**B. Pertinent Laboratory Findings**

1. Positive information from mammography if available. May be accepted as the only clinical basis for biopsy.
2. Positive information from biopsy; needle aspiration or excisional if clinically applicable.
3. Positive information from other studies if clinically applicable such as:
  - a. Skeletal X-ray survey.
  - b. Bone scan.
  - c. Thermogram.
  - d. Tissue estrogen receptor site test.
  - e. Brain isotope or CT scan.
  - f. Liver scan.

**III Initial Length of Stay**

- A. Local excision (lumpectomy, partial mastectomy)—two days.**
- B. Simple mastectomy (complete)—four days.**
- C. Modified radical mastectomy—six days.**
- D. Radical mastectomy—seven days.**

**IV. Extension**

**A. General**

**B. Specific**

- 1. Excessive wound swelling or drainage.**
- 2. Radiation and/or chemotherapy treatment.**

**DIGESTIVE**

**Anal Fistulotomy, Fistulectomy, Sphincterotomy**  
**Gastrectomy--Stomach Malignancy**  
**Gastric Pouch Formation or Gastric Bypass**  
**Hiatal Hernia Surgery**  
**Jejuno-Ileal Shunt**

***Anal Fistulotomy, Fistulectomy, Sphincterotomy***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Perianal Pain, bleeding, and/or swelling with drainage and
2. Findings on anal and digital rectal exam of:
  - a. Fissure in ano not responsive to adequate medical management (sitz baths, stool softeners, anaesthetic ointments).
  - b. Perianal abscess.
  - c. Anal sinus or fistula.

**B. Laboratory Studies**

**A. Anoscopy.**

**II. Documentation**

**A. Pertinent Clinical Findings.**

1. Complete descriptions of symptoms and abnormal anal findings and
2. Duration and type of medical therapy trial for fissure in ano cases and
3. Description of the extent of any anal sinus or fistula and associated symptoms.

**B. Pertinent Laboratory Findings**

Findings from:

1. Anal and digital rectal examination.
2. Anoscopy.

III. Initial Length of Stay

- A. Fissure in ano—ambulatory.
- B. Abscess—three days.
- C. Chronic fistula in ano—three days.

IV. Extension

- A. General
- B. Specific
  - 1. Abscess extension.
  - 2. Sphincter damage.

## **Gastrectomy--Stomach Malignancy**

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. Hematemesis and/or
2. Melena and/or
3. Pain and/or
4. Weight loss and/or
5. Palpable gastric area mass on examination.

#### **B. Laboratory Studies**

1. Gastrointestinal X-ray series.
2. Gastric endoscopy and biopsy.
3. CT scan of abdomen.  
Only in unusual circumstances.
4. Liver scan.
5. Gastric analysis.
6. CEA test.

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

1. Description of the nature and extent of the gastrointestinal bleeding.
2. Amount of the weight loss relative to diet.
3. Description of any pain.

#### **B. Pertinent Laboratory Findings**

Positive findings of malignancy from:

1. Gastrointestinal X-ray series and/or
2. CT scan of stomach area and/or
3. Gastric endoscopy and biopsy.

**III. Initial Length of Stay**

**A. Operated—12 days.**

**IV. Extension**

**A. General**

**B. Specific**

- 1. Peritonitis.**
- 2. Abdominal abscess.**
- 3. Wound infection or disruption.**

***Gastric Pouch Formation or Gastric Bypass--Generally Excluded From Coverage***



***Hiatal Hernia Surgery—Generally Excluded From Coverage***

***Jejuno-Ileal Shunt—Generally Excluded From Coverage***

**URINARY**

**Kidney Transplant (Isograft or Allograft)**

**Kidney Transplant (Isograft or Allograft)****I. Clinical Information****A. Signs and Symptoms**

1. Evidence of chronic irreversible renal insufficiency which limits life expectancy to a few weeks or months and any
2. Clinical status of the patient should be such that the patient can withstand the operational trauma after maximum improvement from preoperative care and
3. The patient should be free of major infection at the time of transplantation and have
4. A relatively normal lower urinary excretory tract and there must be
5. Documentation that a satisfactory donor is available who has already been checked out by examination, renal function tests, and histocompatibility tests.

**B. Laboratory Studies**

1. Initial laboratory usually shows anemia, azotemia, acidosis, and a creatinine clearance of less than 20 ml. per minute.
2. Dialysis unit available.
3. Renal function tests.
4. Histocompatibility tests (HLA and MB antigens).

**II. Documentation****A. Pertinent Clinical Findings**

Information to verify chronic, irreversible renal insufficiency and in which,

1. Life expectancy is limited to weeks or months.
2. Patient is free of major infection.
3. There is a relatively normal lower urinary tract.
4. A satisfactory donor is available and qualifies by examination, renal function, and histocompatibility tests.

**B. Pertinent Laboratory Findings**

1. Evidence of azotemia.
2. Creatinine clearance of less than 20 ml. per minute.

3. Findings from other renal function tests.
4. Findings from histocompatibility tests.

### III. Initial Length of Stay

- A. Recipient—21 days.
- B. Donor—ten days (includes a nonbeneficiary donor by prior authorization—MIO OIL 27-74)

### IV. Extension

- A. General
- B. Specific

1. Infarction of transplant.
2. Acute transplant rejection.
3. Ureteral obstruction.
4. Urinary fistula.
5. Drug toxicity and leukopenia.

**MALE GENITAL**

**Inguinal Herniorraphy  
Prostatectomy**

***Inguinal Herniorraphy--Over Age 12 (Generally Excluded From Coverage)***

**I. Clinical Information**

**A. Sign and Symptoms**

1. Defect in the wall of the inguinal canal with
2. Discomfort interfering with activities of daily living due to bulging of the inguinal canal area with
3. Bulging of the intestinal sac into the defect, whether or not reducible, and there may be
4. Bulging of the sac into the scrotum.

**B. Laboratory Studies**

Routine.

**II. Documentation**

**A. Pertinent Clinical Findings**

1. Information concerning the duration and progression of the hernia and the degree of incapacity.
2. Examination information reveals:

Bulging of tissues, at times to include the intestinal sac, through a two centimeter or larger defect in the inguinal ring area.

**B. Pertinent Laboratory Findings**

Not applicable.

**III. Initial Length of Stay**

- A. Adults--excluded.
- B. Infants and children--ambulatory to one day.

**IV. Extension**

- A. General
- B. Specific

1. Nerve or bladder damage.
2. Ligation of blood supply to testes.



**Prostatectomy****I. Clinical Information****A. Signs and Symptoms**

1. Prostatism manifested by:
  - a. Hesitancy and straining in micturition.
  - b. Reduced force and caliber of urinary stream.
  - c. Frequency, dribbling, and nocturia.
  - d. Episodes of urinary retention may occur.
  - e. Hematuria and pyuria may occur.
2. Finding may include:
  - a. Prostatic enlargement by rectal exam.
  - b. Abnormal hard consistency of the prostate.
  - c. Evidence of median bar enlargement.
  - d. Evidence of bony metastases and elevated serum acid phosphatase if carcinoma has extended beyond the prostatic capsule.
  - e. Prostatic abscess.

**B. Laboratory Studies**

1. Urinalysis and residual urine.
2. Cystoscopy.
3. Cyslogram and urethrogram.
4. Pyelogram.
5. X-ray--skeletal survey.
6. Bone scan.
7. Serum acid phosphatase test.
8. Pathological examination of tissue.

## II. Documentation

### A. Pertinent Clinical Findings.

Information must indicate evidence of:

1. Prostatism manifested by:
  - a. Hesitancy and straining at urination and/or
  - b. Reduced force and caliber of urinary stream and/or
  - c. Urinary frequency, dribbling, and nocturia and/or
  - d. Episodes or urinary retention may occur.
2. Findings on examination of:
  - a. Prostatic enlargement and/or
  - b. Abnormal hard consistency of prostate or
  - c. Median bar enlargement or
  - d. Evidence of prostatic abscess.

### B. Pertinent Laboratory Findings

Positive information from:

1. Residual urine
2. Cystoscopy.
3. Other studies if clinically applicable such as:
  - a. Urethrogram and cystogram.
  - b. Pyelogram.
  - c. Bone scan.
  - d. Serum acid phosphatase test.
  - e. Biopsy report.

## III. Initial Length of Stay

- A. Transurethral—five days.
- B. Suprapubic—eight days.

C. Retropubic—eight days.

D. Perineal—ten days.

IV. Extension

A. General

B. Specific

1. Urinary fistula.
2. Severe urinary incontinence.
3. Hemorrhage.
4. Orchiectomy indicated.

**FEMALE GENITAL**

**Dilatation and Curettage  
Hysterectomy**

***Dilatation and Curettage*****I. Clinical Information****A. Signs and Symptoms**

1. Abnormal uterine bleeding, not medication or endocrine induced.
2. Dysmenorrhea.
3. Pelvic mass.
4. Foreign body (IUD, other).
5. Hematometra or pyometra.
6. Pregnancy to be terminated.
7. Incomplete abortion.
8. Retained secundines.

**B. Laboratory Studies**

1. Pap smear.
2. Endometrial aspiration.
3. Pregnancy test.
4. X-ray or sonogram for pelvic mass and/or foreign body.
5. Endocrine studies.

**II. Documentation****A. Pertinent Clinical Findings**

Clinical data concerning the abnormal uterine bleeding and/or other suspected gynecological condition such as:

1. Duration and type of uterine bleeding.
2. Data precluding endocrine or medication cause of bleeding.
3. History and supportive information for foreign body.
4. Details of incomplete abortion.
5. Voluntary abortion—pregnancy duration and information regarding informed consent.

6. Postpregnancy bleeding—duration and events.
7. Complete pelvic examination, information is required concerning all conditions.

**B. Pertinent Laboratory Findings**

1. Pap smear in suspected neoplasm.
2. Pregnancy test results in voluntary abortion cases.
3. Endometrial aspiration findings (if clinically applicable).
4. Findings from X-ray or sonogram in cases of pelvic mass and/or foreign body.

**III. Initial Length of Stay**

**A. Diagnostic**

Hospital outpatient visit.

**B. Therapeutic**

1. General anesthesia—one day.
2. Local anesthesia—hospital outpatient visit.

**IV. Extension**

**A. General**

**B. Specific**

1. Perforation of uterus.
2. Hemorrhage.
3. Pathologic examination indicating additional immediate treatment.

**Hysterectomy****I. Clinical Information****A. Signs and Symptoms**

1. **Abnormal uterine bleeding not due to medication such as contraceptive agents or to remediable endocrine dysfunction.**
  - a. **Menometrorrhagia, to include post tubal ligation syndrome unresponsive to dilatation and curettage and/or hormonal treatment.**
  - b. **Hemorrhage, acute, severe.**
2. **Premalignant and malignant conditions of the uterine cervix.**
  - a. **Carcinoma in situ.**
  - b. **Recurrent dysplasia on at least two separate biopsies. In these cases invasive carcinoma must have been excluded by colposcopy with biopsy or cold cone and fractional dilatation and curettage.**
3. **Fibroids of the uterus which are either:**
  - a. **Symptomatic, e.g., causing bladder pressure, abnormal bleeding, ureteral or bowel compression, or chronic pelvic pain.**
  - b. **Asymptomatic, but uterus and fibroid(s) are 12 centimeters or greater in diameter.**
  - c. **Fibroid(s) are demonstrating rapid progressive enlargement.**
4. **Evidence of malignant disease of the uterus, ovaries, or fallopian tubes.**
5. **Premalignant lesions of the endometrium:**
  - a. **Atypical or recurrent hyperplasia of the endometrium.**
  - b. **Adenomatous hyperplasia (pertaining to adenoma or to nodular hyperplasia). In these cases adenocarcinoma of the endometrium must have been excluded by adequate endometrial biopsy or fractional dilatation and curettage.**
6. **Chronic, recurrent, severe pelvic inflammatory disease with severe pain, and recurrent discharge; not responsive to medical therapy; and with positive laparoscopic findings.**
7. **Hysterectomy may be performed in conjunction with vaginal repair of symptomatic pelvic floor relaxation associated with either cystourethrocele, rectocele, enterocele, or uterine prolapse.**

8. Invasive hydatidiform mole.

#### B. Laboratory Studies

1. Cervico-vaginal cytologic examination.
2. Dilatation and curettage.
3. Conization.
4. Endometrial biopsy.
5. Pelvic X-ray.
6. Sonogram of pelvis (may be indicated).
7. Colposcopic examination (may be indicated).
8. Laparoscopic examination (may be indicated).

### II. Documentation

#### A. Pertinent Clinical Findings

1. Complete information regarding the duration, severity, and pelvic examination findings concerning the specific condition.
2. Specific information regarding:
  - a. Menometrorrhagia, duration, evidence of unresponsiveness to D&C, and/or hormonal treatment, enough to cause significant anemia.
  - b. Specific symptoms and size of fibroids or evidence of rapid progression in size, or impinging on rectum or bladder.
  - c. Duration, severity, and therapy trials in chronic pelvic inflammatory disease and laparoscopic findings.
  - d. Detailed description of symptoms of pelvic floor relaxation as regards degree of prolapse and associated bladder and/or bowel dysfunction.
  - e. Evidence for invasive hydatidiform mole.

#### B. Pertinent Laboratory Findings

Information from pathological examination of biopsy of tissue in cases of:

1. Carcinoma in situ, cervix or uterus.
2. Recurrent dysplasia on at least two separate biopsies. In these cases invasive carcinoma must have been excluded by colposcopy with biopsy or cold cone and fractional dilatation and curettage.



3. Atypical hyperplasia of uterine endometrium.
4. Adenomatous hyperplasia of endometrium.
5. Adenocarcinoma of the endometrium.

III. Initial Length of Stay

- A. Vaginal—five days.
- B. Total abdominal—six days.

IV. Extension

- A. General
- B. Specific
  - 1 Pelvic abscess.
  2. Vesico—vaginal fistula.
  3. Trauma to either ureter.
  4. Perforation of the bowel.

**NERVOUS**

**Cranioplasty  
Dorsal Column Stimulator--Placement  
Pain--Intracerebral Electrode Implantation  
Portacaval Shunt**

5.1.45

## **Cranioplasty**

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. Repair of skull defect necessary to protect underlying brain tissue, e.g., defects over four to five cm. in diameter over exposed surface areas and especially over the frontal area or the cortical motor strip region (motor strip lies four cm. posterior to mid anterior-posterior [bregma-odontoid line] and angles down from this vertex point toward the eye).
2. Skull defect repair usually not recommended until one year later for post traumatic defects.
3. Closure of small defects under the temporalis muscles and posterior skull rim defects are usually not medically indicated.
4. Closure of skull defects to relieve neurologic symptoms is usually not justified.

#### **B. Laboratory Studies**

Skull series.

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

Description of the skull defect as to size, location, associated symptoms, and length of time since any trauma.

#### **B. Pertinent Laboratory Findings**

Positive findings from a recent skull series.

### **III. Initial Length of Stay**

Six days.

### **IV. Extension**

#### **A. General**

#### **B. Specific**

1. Excessive swelling at plate site.
2. Skin fistula.

*Dorsal Column Stimulator--Placement (Generally Excluded From Coverage)*

***Pain—Intracerebral Electrode Implantation***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Chronic, intractable, severe pain of diffuse type which
2. Has not been responsive to documented medical, surgical, or physical therapy techniques and which is
3. Of long duration (six months plus) and constant nature and
4. Which is interfering with general and specific functioning of the patient in necessary daily living.

**B. Laboratory Studies**

Not applicable.

**II. Documentation**

**A. Pertinent Clinical Findings**

Complete details concerning:

1. Pain condition as to:
  - a. Location.
  - b. Type.
  - c. Severity.
2. Types and duration of medical, surgical, and/or physical therapy trials.
3. Description of how the pain problem interferes with the patient's functioning.

**B. Pertinent Laboratory Findings**

No applicable.

**III. Initial Length of Stay—Seven Days**

**IV. Extension**

**A. General**

**B. Specific**

- 1. Implant lead breakage.**
- 2. Cerebral hemorrhage.**
- 3. Spinal fluid leak.**

***Portacaval Shunt***

**I. Clinical Information**

**A. Signs and Symptoms**

Recurrent hemorrhage from demonstrated esophageal varices.

**B. Laboratory Studies**

1. Liver function tests.
2. Esophagram.
3. Endoscopy.

**II. Documentation**

**A. Pertinent Clinical Findings**

Information indicates evidence of:

1. Recurrent hemorrhage from demonstrated esophageal varices.
2. Preferable, but not mandatory, information is:
  - a. Patient is under age 60 years.
  - b. Liver function is no more than moderately decreased.
  - c. Absence of ascites.

**B. Pertinent Laboratory Findings**

Positive information from:

1. Liver function tests.
2. Esophagram.
3. Endoscopy.

**III. Initial Length of Stay**

Ten days.

**IV. Extension**

**A. General**

**B. Specific**

Shunt occlusion.

**EYE, EAR, AND NOSE**

**Ethmoidectomy--Intranasal  
Glaucoma Surgery--Angle Closure  
Glaucoma Surgery--Open Angle  
Keratoplasty  
Mastoidectomy  
Myringotomy  
Nasolacrimal Duct Obstruction--Surgery  
Retinal Detachment  
Rhinoplasty**



***Ethmoidectomy--Intranasal***

**I. Clinical Information**

**A. Signs and Symptoms**

Nasal pain and discharge and bleeding with:

1. Polypoid hypertrophy in the anterior and posterior ethmoid cells with
2. Chronic suppuration of anterior and posterior ethmoid cells.
3. Persistent swelling and/or pain secondary to ethmoid infection, not responsive to medical therapy.
4. Evidence or suspicion of neoplasm in ethmoid sinus.

**B. Laboratory Studies**

1. X-ray--sinuses and/or
2. CT scan--sinuses.
3. Pathological examination of tissue.

**II. Documentation**

**A. Pertinent Clinical Findings**

Complete otolaryngological examination, history, and report concerning:

1. Duration and frequency of any nasal pain, discharge, bleeding and
2. Description of pertinent nasal signs of mucosal change and
3. Complete description of duration and types of appropriate medical therapy trials for conditions such as chronic ethmoid infection.

**B. Pertinent Laboratory Findings**

Copy of original report of X-ray or CT findings of sinus views.

**III. Initial Length of Stay**

Two days.

**IV. Extension**

**A. General**

**B. Specific**

1. Hemorrhage.
2. Intracranial complications.

## ***Glaucoma Surgery--Angle Closure***

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. Sudden onset of blurring and dimness of vision with
2. Progressive decrease in best corrected *visual acuity* and/or visual field of the affected eye, and may note,
3. Halos or colored rings around lights and/or
4. Pain or aching around the eye with
5. Examination findings of acute angle closure with the ocular tension increased.
6. History of acute angle closure glaucoma in the contralateral eye may indicate a need for prophylactic surgical therapy in the good eye.

#### **B. Laboratory Studies**

1. Ophthalmological examination to include best corrected visual acuity and fundus examination in both eyes.
2. Tonometry.
3. Visual field examination.
4. Gonioscopy.

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

1. Findings indicating progressive visual acuity and/or visual field loss due to glaucoma with
2. Findings indicating acute nature of the problem which precludes medical therapy trial.
3. History to support prophylactic surgery in the second eye of a patient with history of angle closure glaucoma.

#### **B Pertinent Laboratory Findings**

Findings from complete ophthalmological examination to include:

1. Best corrected visual acuity and fundus examination in both eyes.
2. Visual field examination.
3. Tonometry.
4. Gonioscopy findings.

### III. Initial Length of Stay

- A. Inidectomy--three days.
- B. Filtering procedure--four days.

### IV Extension

#### A. General

#### B. Specific

1. Persistent severe pain.
2. Persistent increased ocular tension.
3. Hemorrhage.
4. Flat anterior chamber.
5. Intraocular infection.

***Glaucoma Surgery--Open Angle***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Visual blurring, decreasing visual acuity, and frequent eye pain with finding of:
2. Progressive visual acuity and visual field loss due to glaucoma in spite of medical management.

**B. Laboratory Studies**

1. Ophthalmological examination to include fundus examination and best corrected visual acuity in both eyes.
2. Tonometry.
3. Visual field examination.
4. Gonioscopy.

**II. Documentation**

**A. Pertinent Clinical Findings**

1. Findings indicate progressive visual acuity and/or visual field loss due to glaucoma and
2. Evidence of inadequate response to medical management.
3. Poor or noncompliance to medical management on the patient's part.

**B. Pertinent Laboratory Findings**

Findings from complete ophthalmological examination to include:

1. Best corrected visual acuity and fundus examination in both eyes.
2. Tonometry.
3. Visual field examination.
4. Gonioscopy findings if clinically applicable.

**III. Initial Length of Stay**

Three days.

**IV. Extension**

**A. General**

**B. Specific**

- 1. Persistent severe pain.**
- 2. Persistent increased ocular tension.**
- 3. Hemorrhage.**
- 4. Shallow or flat anterior chamber.**
- 5. Intraocular infection.**

***Keratoplasty***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Visual blurring, possible pain, and corneal deformity with evidence of:
  - a. Acute corneal hydrops or
  - b. Descemetocoele or
  - c. Evidence of corneal damage due to injury or disease with
2. Corneal functional visual disability with retinal function relatively intact in the involved eye.

**B. Laboratory Studies**

1. Ophthalmologic examination.
2. Slit lamp examination.
3. Tonometry.

**II. Documentation**

**A. Pertinent Clinical Findings**

Examination information indicates definite functional visual disability due to conditions such as:

1. Acute corneal hydrops.
2. Descemetocoele.
3. Scarred cornea due to disease or injury.

**B. Pertinent Laboratory Findings**

1. Ophthalmologic examination to include:
  - a. Complete description of the corneal abnormality.
  - b. Best corrected visual acuity of both eyes.
  - c. Description of the functional visual disability due to the corneal condition and retinal status in the involved eye(s).

2. Slit lamp examination findings.

3. Tonometry findings.

**III. Initial Length of Stay**

Transplant of cornea—seven days.

**IV. Extension**

**A. General**

**B. Specific**

1. Perforation of wound site.

2. Infection.

3. Flat anterior chamber.

4. Glaucoma.



## **Mastoidectomy**

### **I. Clinical Information**

#### **A. Signs and Symptoms**

1. Pain, tenderness, and/or swelling in the mastoid bone area and may have
2. Hearing loss on the affected side with evidence of,
3. Persistent infection which has extended into the mastoid bone area which is
4. Unresponsive to adequate medical therapy.
5. Cholesteatoma which has extended beyond the confines of the middle ear and
6. Complications of labyrinth, central nervous system, or facial nerve function in the presence of mastoid disease.

#### **B. Laboratory Studies**

1. X-rays—Mastoid Area. X-ray changes in the presence of chronic infection or cholesteatoma which show destruction of the contents of the epitympanic space and the cells of the antrum and/or mastoid area.
2. Audiogram.
3. Pathologic culture and tissue examination.

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

Information must indicate:

1. Persistent mastoid area infection beyond the confines of the middle ear which is unresponsive to adequate trials of medical therapy or
2. Cholesteatoma extending beyond the confines of the middle ear or
3. To aid in treating complications of mastoid disease (infection/tumor) as regard labyrinth, central nervous system, or facial nerve function.

#### **B. Pertinent Laboratory Findings**

1. Copy of original X-ray report must show changes in the presence of chronic infection or cholesteatoma of destruction/involvement of the contents of the epitympanic space and the cells of the antrum and/or mastoid area.

2. Positive information as clinically applicable from:

a. Audiogram.

b. Pathologic culture and/or tissue examination.

**III. Initial Length of Stay**

Three days.

**IV. Extension**

**A. General**

**B. Specific**

1. Severe labyrinthine imbalance.

2. Lateral sinus thrombosis.

3. Intracranial extension of infection.

## ***Myringotomy***

### **I. Clinical Information**

#### **A. Signs and Symptoms**

**Inflammatory disease of the middle ear and/or tympanic membrane as evidenced by acute or chronic otitis media with one or more of the following:**

- 1. Bulging eardrum with pain.**
- 2. Fever.**
- 3. Hearing loss may occur.**
- 4. Ear canal drainage (serous or purulent) may occur.**
- 5. Vertigo may occur.**

#### **B. Laboratory Studies**

- 1. Culture and sensitivity.**
- 2. Audiogram.**

### **II. Documentation**

#### **A. Pertinent Clinical Findings**

**Information indicates:**

- 1. Acute otitis media unresponsive to medical treatment requiring culture.**
- 2. Acute otitis media with severely bulging eardrum and severe pain.**
- 3. Chronic serous otitis media unresponsive to medical treatment.**

#### **B. Pertinent Laboratory Findings**

**Information from cultures if clinically applicable.**

### **III. Initial Length of Stay**

- A. Outpatient visit.**

**IV. Extension (if hospitalized)**

**A. General**

**B. Specific**

- 1. Labyrinthine imbalance.**
- 2. Mastoiditis.**

***Nasolacrimal Duct Obstruction--Surgery, Type to be Specified***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Chronic tearing.
2. Probing of nasolacrimal duct ineffective.
3. Chronic conjunctivitis may occur.
4. Infraction of turbinate obstructive of duct.

**B. Laboratory Studies**

Dacryocystogram.

**II. Documentation**

**A. Pertinent Clinical Findings**

Information indicating a condition of:

1. Chronic tearing and
2. Probing of nasolacrimal duct ineffective.

**B. Pertinent Laboratory Findings**

Information from dacryocystogram if clinically applicable.

**III. Initial Length of Stay**

Ambulatory surgery.

**IV. Extension**

**A. General**

**B. Specific**

1. Orbital infection.
2. Nasal hemorrhage.

***Retinal Detachment***

**I. Clinical Information**

**A. Signs and Symptoms**

1. Acute visual loss and/or persistent "veil effect" of vision (especially in individuals over age 50 with myopia and aphakia) with
2. Finding of retinal detachment on ophthalmological examination and/or
3. Retinal tears.

**B. Laboratory Studies**

1. Ophthalmologic examination.
2. Ophthalmoscopy.
3. Tonometry.
4. Visual field examination.
5. Ultrasound (A or B scan).
6. Goldman type 3 mirror lens examination.

**II. Documentation**

**A. Pertinent Clinical Information**

Information may indicate evidence of:

1. Acute visual loss or
2. Ophthalmological examination evidence of:
  - a. Retinal detachment and/or
  - b. Symptomatic retinal tears.
  - c. Asymptomatic retinal tears.
  - d. Retinal tears or degeneration in fellow eye or when family history indicates treatments.

**B. Pertinent Laboratory Findings**

Positive information from other studies as clinically applicable such as:

1. Ophthalmoscopy.
2. Tonometry.
3. Visual field examination.

**III. Initial Length of Stay**

- A. Argon laser or xenon photocoagulation—outpatient visit.
- B. Surgical repair—six days.

**IV. Extension**

**A. General**

**B. Specific**

1. Failure of reattachment.
2. Retinal hemorrhage.
3. Endophthalmitis.
4. Glaucoma.

*Rhinoplasty--Generally Excluded From Coverage*



**CRITERIA MANUAL CHAPTER 5.2**  
**PSYCHIATRIC DIAGNOSES**

## PSYCHIATRIC DIAGNOSES

Criteria for hospital services for specific psychiatric diagnoses are presented in the following format:

### ***Model Format and General Criteria***

#### I. Clinical Information

##### ***Indications for Admission***

Usual indications for admission common to all disorders are:

- A. Danger to self, others, or property as a result of a mental disorder and/or
- B. Seriously disordered behavior accompanied by impaired reality testing and/or
- C. Need for planned medical evaluation, special drug therapy, or special treatment requiring continued hospitalization or continuous skilled observation following failure of treatment modalities available in outpatient, community, or extended care settings and accompanied by impaired social, familial, and/or occupational functioning.
- D. Specific additional indications as listed under the particular diagnosis.

#### II. Documentation

##### A. Pertinent Clinical Findings

Documentation of clinical information and indications for admission listed in I above.

##### B. Pertinent Laboratory Findings

#### III. Review Interval

After admission, the maximum period of hospitalization without review is listed under each diagnosis. This is neither an assurance nor a limitation of the length of stay which may be allowable according to the documented medical necessity in the individual case. If the diagnosis is changed during the course of hospitalization, the review interval associated with the new diagnosis will apply.

#### IV. Medical Indications for Continued Stay

Continued stay will be based on medical necessity as documented by the attending physician (and others) in the patient's clinical record. Usual reasons for extensions of initial stays common to all disorders are the following:

- E. Continuation of indications for admission without the presence of a discharge criterion (see below).
- F. Serious adverse reaction to drugs, procedures, or therapies.
- G–H. Specific additional indications as listed under the particular diagnosis.

***Neuroses, Personality Disorders, Psychophysiological Disorders***

Indications for Admission: A, B, C.

Review Interval: Seven days for adult.  
Fourteen days for child or adolescent.

Extension: E, F.

***Transient Situational Disturbances***

Indications for Admission: A, B, C.

Review Interval: Three days for adult.  
Seven days for adolescent.

Extension: E, F.

***Organic Brain Syndromes*** (Excluding Alcohol or Drug Conditions)

Indications for Admission: A, B, C, in addition D.

- D. Impaired judgment, memory, intellect, orientation, or attention span or confusion (any two) when accompanied by difficulty in controlling patient.

Review Interval: Seven days for adult.  
Fourteen days for child or adolescent.

Extension: E, F, in addition G and H.

G. Medical/surgical problems.

H. Additional inpatient stay required to complete establishment of etiology.

***Psychoses, With Organic Brain Syndrome***

Indications for Admission: A, B, C.

Review Interval: Seven days for adult.  
Fourteen days for child or adolescent.

Extension: E, F.

***Psychoses: Involitional, Depressive***

Indications for Admission: A, B, C.

Review Interval: Fourteen days.

Extension: E, F.



***Schizophrenia***

Indications for Admission: A, B, C.

Review Interval: Fourteen days.

Extension: E, F.

***Manic Depressive Illness*** (Manic, Depressive, or Circular Type)

Indications for Admission: A, B, C.

Review interval: Fourteen days.

Extension: E, F.

***Psychoses, Childhood*** (Infantile Autism, Childhood Schizophrenia, etc., Diagnosis Should be Carefully Documented.)

Indications for Admission: A, B, C.

Review Interval:   Seven days for adult.  
                          Fourteen days for child or adolescent.

Extension: E, F.

***Behavior Disorders of Childhood and Adolescence*** (Diagnosis Should be Carefully Documented.)

Indications for Admission: A, B, C.

Review Interval: Twenty-one days.

Extension: E, F.

***Alcohol Addiction***

Treatment of alcoholism *per se* is *not* a covered benefit under the Medi-Cal program. Documented medical disorders, whether related or unrelated to alcoholism, may be justification for admission to a hospital; however, these medical disorders must be supported by information similar in scope to that required for other diagnoses identified in the appropriate section.

***Drug Dependence***

Treatment of drug dependence *per se* is not a covered benefit under the Medi-Cal program.

***Drug Overdose and Withdrawal***

Detoxification from narcotics is only covered on an outpatient basis. Only medical treatment for drug overdose and life-threatening withdrawal from barbiturates, sedatives, or hypnotics may be covered.

Indications for Admission: A, B, C, in addition D.

D. Life-threatening withdrawal from barbiturates, sedatives, hypnotics, and/or "tranquilizers."

Review Interval: Seven days.

Extension: E, F.

## ACUTE AND TRANSITIONAL INPATIENT CARE ADMINISTRATIVE DAYS

- I. Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of medical care than that currently needed by the patient. These days may be authorized for patients awaiting placement in transitional inpatient care (TC) units, skilled nursing facilities (SNFs), or intermediate care facilities (ICFs).
  
- II. A patient who has been approved for acute administrative days, and whose medical and nursing needs exceed the level of care available in SNFs and ICFs in the community, according to the professional judgment of the Medi-Cal consultant, will be designated as a heavy care patient for the purpose of approving continued Medi-Cal authorization. The following are factors to be considered by the Medi-Cal Consultant when making a determination if a patient qualifies as a heavy care patient:
  - A. The information obtained from the attending physician and/or review of the medical record indicates that the medical and nursing needs of the patient exceed the level of care currently available in SNFs/ICFs in the community. A patient will be designated as a heavy care patient until such time as an appropriate placement becomes available within the community or the patient's care needs change to SNF/ICF manageable care.
  
  - B. The amount, level, and frequency of services necessary for the care of the patient exceed the community standard for SNF/ICF level of care. A patient will be designated as a heavy care patient until such time as the patient can be reasonably placed in an adjacent community with the community standard for SNF/ICF care appropriate to the patient's care needs or the patient changes to SNF/ICF manageable care within the community.

When the Medi-Cal Consultant designates a patient as heavy care, he/she shall authorize continuing care for that patient as an acute level of care patient.
  
- III. Acute administrative days for TC, SNF care, or ICF care; and acute care days for heavy care patients, may be authorized, subject to the following:
  - A. Appropriate and Timely Discharge
    1. The acute facility shall initiate placement efforts prior to the termination of acute care coverage and shall document such efforts and contacts.
  
    2. The administrator of the local Medi-Cal field office has the authority to determine the number of facilities that are called daily in attempts to place any particular patient. The administrator may consider factors such as the availability of SNF/ICF beds in the geographical area, the number of TC providers in the Health Facility Planning Area and the number of SNFs/ICFs available in the geographical area staffed to meet the needs of developmentally disabled patients or mentally disordered patients in determining the number of daily calls to be made in each specific case.
  
    3. The calls being made can cover any number of patients being placed provided that:
      - a. There is documentation in the record that each patient was discussed as a placement possibility.
  
      - b. The SNF/ICF meets the special needs of a particular patient, e.g., requires ICF/DD or locked facility. If the efforts are for TC placement, documentation specifies the TC units contacted meet the special needs of the patient, e.g., transitional rehabilitation care or transitional medical care.



4. Administrative days shall only be authorized effective the day the required number of calls have been completed, provided all other requirements are met.
5. The acute inpatient facility, if none of the SNFs/ICFs called will accept the patient, may request the local Medi-Cal field office to issue a date control number for administrative days. The date control number may be issued for a period up to 30 days. The following information shall be sent to the local Medi-Cal field office at the time of the request.
  - a. A copy of nursing notes, progress notes, and physician's order for the last covered week of acute care;
  - b. Documentation of placement efforts;
  - c. Documentation of Medicare denial; and
  - d. A completed MC 18-1, signed by the attending physician, specifying the date, noting that it is a request for acute administrative days.
6. The acute inpatient facility shall continue placement efforts until placement has taken place or until the placement of the patient within a week can be documented by the facility to the satisfaction of the Medi-Cal Consultant. The acute inpatient facility shall submit the documentation to the local Medi-Cal field office at the end of the period covered by the date control number or upon patient admission to a TC unit, SNF, or ICF.
7. Administrative days shall not be authorized in an acute inpatient facility having designated swing beds unless the hospital's designated swing beds are at full occupancy.

#### B. Utilization of Other Coverage

1. The acute inpatient facility shall utilize all other insurance coverages prior to requesting Medi-Cal authorization.
2. If the level of patient care is determined to be at the Medicare SNF level, the request for administrative days shall be denied if the patient is Medicare eligible and Medicare coverage has not been utilized. The fiscal intermediary denial shall be submitted to the local Medi-Cal field office with the request for transitional inpatient care authorization.
3. Requests for SNF care may be approved for placement in a general acute care hospital distinct part SNF. However, if none is available, acute administrative days may be authorized if the patient is strictly Medi-Cal.
4. If the patient is determined to be at the acute level (for either Medicare or Medi-Cal) and acute services are authorized through a PSRO, requests for administrative days shall be denied.

## CRITERIA MANUAL CHAPTER 5.4

### STABLE FOR TRANSPORT GUIDELINES

- I. A hospital designated as noncontracting may be reimbursed for medically necessary inpatient services provided to beneficiaries in life threatening or emergency situations that could result in permanent impairment.
- II. Once the Medi-Cal medical consultant determines that a patient was appropriately admitted to a noncontracting hospital on an emergency basis, the Medi-Cal medical consultant shall authorize one day of acute hospital stay. "Appropriately admitted" means the patient's condition met the definition of an emergency condition and the patient was admitted with a reasonable expectation that the patient would remain overnight, even if he or she does not actually remain in the facility overnight.

Authorization of any additional days of stay at the noncontracting hospital beyond the first day should be granted only if the patient's condition is not stable for transport as defined below. However, once this patient's condition is stable based upon these guidelines, the patient is no longer considered to be in an emergency situation. Therefore, Medi-Cal reimbursement should no longer be available to the noncontracting hospital.

- III. Medical stability is defined as an acute care patient able to reasonably sustain a transport in an Emergency Medical Technician I (EMT I) staffed ambulance, with no expected increase in morbidity or mortality.
- IV. A hospital designated as noncontracting may receive Medi-Cal reimbursement for inpatient acute hospital services provided to Medi-Cal beneficiaries who have Medicare coverage. The noncontract hospital is reimbursed for those medically necessary services not covered by Medicare, e.g., the deductible. However, if a Medi-Cal/Medicare beneficiary's hospital inpatient Medicare coverage is exhausted, the noncontract hospital will only be reimbursed by the Medi-Cal program, if the Medi-Cal/Medicare beneficiary is in a life threatening or emergency situation that could result in permanent impairment, and the beneficiary's condition does not meet the definition of stable for transport.
- V. The professional judgment of the Medi-Cal medical consultant will be utilized to distinguish a patient whose condition meets the definition of stable for transport from a patient whose condition does not meet the definition of stable for transport for the purpose of approving Medi-Cal authorization within noncontract hospitals. The following factors shall be used as guidelines by the Medi-Cal consultant when making a determination:

#### A. *General Condition*

##### 1. Stable

Patients considered stable for transport in an EMT I staffed ambulance should have stable blood pressure and pulse, and be breathing on their own. They may have a normal or reduced level of consciousness, but should be stable at that level.

## 2. Unstable

Patients who require an intensive care level of monitoring of their vital signs (pulse, respiration, blood pressure) or require the bedside capacity to intervene in anticipation of a possible rapid decline in their condition are *not* considered stable.

Patients with low, extremely high, or rapidly fluctuating blood pressure are *not* stable.

Patients requiring continuous cardiac monitoring and/or the potential for cardiac resuscitation capability are *not* stable.

## B. *Mobility*

### 1. Stable

Patients considered stable for transport in an EMT I staffed ambulance may include ambulatory and nonambulatory patients, including those requiring splinting or casting of extremities.

Patients requiring traction may also be transferred if either the traction can be arranged to be consistent with transport, or the patient may go without traction for the time required with no expected ill effects.

### 2. Unstable

Patients with unstable spinal fractures are *not* considered stable.

## C. *Drug Requirements*

### 1. Stable

Patients who are on oral or intramuscular (IM) medications are considered stable, providing that no administration of the drug or monitoring of its effects are expected en route.

Patients with IVs may be transferred by an EMT I staffed ambulance if the rate of IVs could vary substantially with no ill effects on the patient and monitoring or intervention by the EMT I is *not* expected.

### 2. Unstable

EMT Is are *not* trained, or authorized to administer, or make any judgments, or interventions in relation to drug administration. Patients whose vital signs or stability is immediately dependent upon proper drug therapy are *not* considered stable for transport in an EMT I staffed ambulance.

Patients requiring a higher level of service during transport than that available with an EMT I staffed ambulance shall *not* be deemed stable for transport unless a compelling medical necessity exists for that transfer (as with burns, or intensive care nursery, etc).

All hospital-to-hospital transport from a noncontract to a contract facility is to occur by ambulance to the nearest contract (or exempt) hospital which has a bed available and the capacity to provide the necessary care and for which the patient can sustain transport as determined by the Medi-Cal medical consultant in accordance with the above criteria. Prior authorization requirements for the transport will continue in the usual manner.

## **CRITERIA MANUAL CHAPTER 5.5**

### **ACUTE INPATIENT INTENSIVE REHABILITATION**

- I. Inpatient intensive rehabilitation hospital services are covered for eligible Medi-Cal patients by the Medi-Cal Program in accordance with Section 14064 of the Welfare and Institutions (W&I) Code. The Department and the rehabilitation community understand and use the term “acute inpatient intensive rehabilitation” to mean the same as the term “inpatient intensive rehabilitation hospital services” as used in the statute. The term “acute inpatient intensive rehabilitation” also includes those rehabilitation services described in W&I Code, Section 14132.8.

Acute inpatient intensive rehabilitation is a program of rehabilitation, as defined in Section II.E, provided to a patient admitted to an acute care bed (certified pursuant to 42 CFR Part 482) in a rehabilitation center, licensed in accordance with Title 22, CCR, Sections 70595 – 70603. The acute intensive rehabilitation shall be provided under the general or direct supervision of a physician, as specified in Section 14064 of the W&I Code. Acute inpatient intensive rehabilitation is intended to help the physically or cognitively impaired patient to achieve or regain his/her maximum potential for mobility, self-care, and independent living by restoring maximum independent function, resulting in a sustained higher level of self care and discharge to home or other community setting, or to a lower level of care, in the shortest possible time.

Acute inpatient intensive rehabilitation services are covered services only when provided to a patient admitted to an acute care bed (certified

pursuant to 42 CFR Part 482) in a rehabilitation center, licensed in accordance with Title 22, CCR, Sections 70595-70603.

- II. For the purposes of adjudicating TARs for acute inpatient intensive rehabilitation, the following definitions shall apply:
- A. “Activities of daily living” means those activities performed by an individual for essential living purposes. These activities shall include grooming, oral hygiene, bathing, toileting, eating, meal preparation, dressing, sleeping, communication, and mobility necessary to perform the above listed activities, to navigate environmental obstacles such as stairs, ramps, and curbs, and to access transportation for the purposes of activities common to everyday living.
- B. “Acute inpatient intensive rehabilitation treatment plan” or “rehabilitation treatment plan” means a written plan for treatment of the patient’s medical condition, which shall include all of the following:
1. A statement(s) of the patient’s medical problem(s).
  2. A description(s) of the intervention(s) determined by the multidisciplinary team to be appropriate for the patient’s problem(s).
  3. The goal(s) of treatment.
  4. The expected outcome(s) of treatment, with specific time frames for the patient to attain the stated goal(s), as determined by the multidisciplinary team.

- C. "Multidisciplinary team" means the group of medical care providers, including those as specified in Title 22, CCR, Section 70599, that are responsible for implementing the rehabilitation treatment plan. Such a team shall be comprised of physicians, nurses, and therapists.
  - D. "Physician" , for the purpose of this chapter, means either the patient's physician or the physician's designee, or a physician employed by, or serving as a consultant to, the rehabilitation hospital.
  - E. "Rehabilitation" means those services specified in Section 14064 of the W&I Code.
- III. Referral shall be made to the California Children's Services (CCS) program for authorization of services and case management, as required by Title 22, CCR, Section 51013, when a person under 21 years of age has a CCS-eligible medical condition as defined in Title 22, CCR, Sections 41800-41876.
- IV. Acute inpatient intensive rehabilitation requires authorization by a Medical Consultant. Authorization shall be based upon medical necessity substantiated by documentation submitted with the Treatment Authorization Request (TAR). Authorization shall be granted in increments of up to 30 days.
- V. Authorization of acute inpatient intensive rehabilitation shall not be granted when the primary reason for the acute inpatient intensive rehabilitation is any of the following:

- A. Education or vocational training.
  - B. Treatment for cardiac or respiratory improvement, in the absence of two or more functional deficits, as specified in Section VI.B.
  - C. Treatment for any medical condition, in the absence of two or more functional deficits, as specified in Section VI.B.
  - D. Treatment for drug or alcohol addiction.
  - E. Behavioral modification therapy, except as a treatment modality for the requirements specified in Section VI.B. of this chapter.
  - F. Treatment for mental illness.
- VI. Initial authorization of acute inpatient intensive rehabilitation shall be granted only when, at a minimum, all of the following conditions are met:
- A. The patient has been evaluated by a physician who has:
    - 1. Determined and documented that the patient requires all of the following:
      - a) 24-hours per day oversight by a physician, with a minimum of two visits per week by the physician and written progress notes at each visit.
      - b) A minimum of 18 hours per week of a combination of two or more of the following therapy disciplines:



- (1) Physical therapy, pursuant to the standards of practice specified in Business and Professions Code Section 2600 et seq., which shall include orthotic or prosthetic training, as specified on the patient's rehabilitation treatment plan, provided by the physical therapist.
- (2) Occupational therapy, pursuant to the standards of practice specified in Business and Professions Code Section 2570 et seq., which shall include orthotic or prosthetic training, as specified on the patient's rehabilitation treatment plan, provided by the occupational therapist.
- (3) Speech therapy, pursuant to the standards of practice specified in Business and Professions Code Section 2530 et seq., which shall include intensive or advanced assistive technology training, such as the use of an augmentative and alternative communication (AAC) device, as specified on the patient's rehabilitation treatment plan, provided by the speech therapist.
- (4) Services provided by a prosthetist or orthotist, such as measuring and fitting of prosthetic or orthotic appliances.

- (5) Psychological and social work services not to exceed 4 hours of the required 18 therapy hours in any given week.
  2. Participated in the development of, or concurred with, the rehabilitation treatment plan developed by the multidisciplinary team, as specified in Section II.B. of this chapter. Such participation or concurrence shall be documented in the patient's medical record.
- B. The patient has a severe functional deficit in two or more of the following areas: , documented by the physician. At least one of the documented functional deficits shall be in the area of activities of daily living skills, mobility skills, safety, or communication.
1. Activities of daily living skills, which shall include those activities specified in Section II.A.
  2. Mobility skills, which shall include ambulation or transfer deficits or wheelchair dependency.
  3. Bladder or bowel control and need for development of a bladder or bowel management program.
  4. Severe pain that markedly limits function, but which will not preclude the patient's participation in the acute inpatient intensive rehabilitation program.
  5. Safety and judgment deficits, which if left untreated would result in injury to the patient or the development of medical complications such as falls, contractures, decubiti, or urinary tract infections.

6. Cognition deficits requiring cognitive evaluation and retraining.
  7. Communication deficits, including severe speech or language impairment or need for training in the use of assistive technology, such as an AAC device in the acute inpatient intensive rehabilitation setting.
- C. The following are documented by the physician:
1. One of the following:
    - a) For the patient without cognitive deficit(s), the patient has been medically and psychologically stable for at least 24 hours and can physically and psychologically tolerate and participate in the proposed acute inpatient intensive rehabilitation program.
    - b) For the patient with cognitive deficit(s), the patient has been medically stable for at least 24 hours and can physically tolerate and participate in the proposed acute inpatient intensive rehabilitation program. The patient's psychological status, as evaluated in light of the cognitive impairment, is considered stable and does not in itself present an obstacle to the accomplishment of the specified goals.

2. One of the following:
  - a) For the patient without cognitive deficit(s), the patient demonstrates understanding of his or her medical condition and the motivation to cooperate with and participate in the proposed acute inpatient intensive rehabilitation program.
  - b) For the patient with cognitive deficit(s), any lack of understanding the patient may have of his or her medical condition will not interfere with his or her ability to participate in the acute inpatient intensive rehabilitation program. The patient demonstrates the ability to follow directions or otherwise cooperate with and participate in the proposed acute inpatient intensive rehabilitation program.
3. There is the expectation by the physician that the patient will be able to improve his/her functional abilities in order to either:
  - a) Regain or attain the ability to provide self-care in activities of daily living, or
  - b) Transition or return to a community setting with or without the assistance of a caregiver, or to a lower level of care.
4. Any concurrent medical or psychological condition(s) that requires monitoring or treatment does not significantly preclude the patient's participation in the acute inpatient

intensive rehabilitation program. If the acute inpatient intensive rehabilitation program is interrupted for treatment of a documented medical or psychological condition for more than three consecutive days, re-institution of acute inpatient intensive rehabilitation shall require the submission of a new TAR. Authorization of acute inpatient intensive rehabilitation in this case shall be granted only when the requirements specified in Section VI. are met.

5. Improvement of the patient's functional abilities cannot be achieved at a lower level of care.

VII. Continuing authorization of acute inpatient intensive rehabilitation shall be granted only when all of the following is documented by the physician:

- A. The criteria specified in Section VI.A., B., and C. are met.
- B. An increased level of functional abilities has been achieved and additional improvement is anticipated.
- C. Acute inpatient intensive rehabilitation is medically necessary to improve the newly achieved functional ability or to achieve improvement in another functional deficit area.
- D. Improvement of the patient's functional abilities cannot be achieved at a lower level of care.
- E. New therapeutic goals and timelines have been established on the rehabilitation treatment plan, as specified in Section II.B., for at least two of the therapy disciplines specified on the previous rehabilitation treatment plan.

- VIII. Continuing authorization of acute inpatient intensive rehabilitation shall not be authorized when any of the following conditions are present, based upon the documentation submitted with the TAR:
- A. All of the established goals have been attained and no further goals are specified on the rehabilitation treatment plan.
  - B. Improvement of the patient's functional abilities has plateaued , resulting in one or more of the goals having not been met and further improvement is not anticipated.
  - C. Improvement of the patient's functional abilities can be achieved at a lower level of care.
  - D. The patient has been unable or unwilling to cooperate with the acute inpatient intensive rehabilitation program.
- IX. Authorization of a trial period of acute inpatient intensive rehabilitation:
- A. When rehabilitation potential is determined by the Medi-Cal consultant to be likely based upon the documentation of criteria specified in Section VI.B., but criteria specified in Sections VI.A. and C. are not fully determined, authorization shall be granted for up to 14 calendar days to determine if improvement in practical function can be accomplished, and to establish medical necessity for continuing acute inpatient intensive rehabilitation.
  - B. Continued authorization beyond 14 calendar days shall be granted only if the criteria specified in Sections VII.A. through E. are met, as

determined by the Medi-Cal consultant, based upon the documentation submitted with the TAR.

- X. In addition to the documentation requirements specified in Sections VI. and VII., the documentation submitted with the TAR for acute inpatient intensive rehabilitation shall include all of the following:
  - A. For initial authorization:
    - 1. A written summary of patient evaluation by a physician, which shall include all of the following:
      - a) Diagnoses, physical findings, and description of functional deficits.
      - b) Pertinent history of functional deficits.
      - c) A summary of the patient's premorbid functional level, which shall include physical, cognitive, psychological, vocational, and family or social functioning.
      - d) A description and results of all previous rehabilitation services related to the requested admission.
      - e) A description of the patient's ability to understand and cooperate with the acute inpatient intensive rehabilitation program as specified in Section VI.C.2. of this chapter.
    - 2. An evaluation of the patient's functional level by each therapy discipline, as specified in Section VI.A.1.(b)(1)

through (5), that is specified on the rehabilitation treatment plan.

3. One of the following:
  - a) A detailed plan for completion of an initial evaluation and rehabilitation treatment plan, as specified in Section IX.A., if the request is for a 14-day trial of acute inpatient intensive rehabilitation.
  - b) A detailed rehabilitation treatment plan, as specified in Section II.B.

B. For continuing authorization:

1. A written summary by a physician, which shall include all of the following:
  - a) Current physical assessment.
  - b) Specific progress for each functional deficit identified in the prior rehabilitation treatment plan.
  - c) Medical justification of continuing need for acute inpatient intensive rehabilitation, which shall include an explanation of why the patient's rehabilitation needs cannot be met at a lower level of care.
2. An updated rehabilitation treatment plan that anticipates improvement in performance of activities of daily living within a specified period of time, as determined by the physician



and multidisciplinary team.

3. Multidisciplinary team conference notes, which shall include documentation of all of the following:
  - a) Participation of all appropriate staff, as specified in Section II.C.
  - b) Measured progress, such as level of functional ability for each goal specified on the rehabilitation treatment plan.
  - c) At least two multidisciplinary team conferences per month.
  - d) Updated discharge plan.
4. Orders by the physician, written within the previous two weeks, specifying rehabilitation services to be provided.
5. Therapy summary, which shall include the number of hours of therapy per week, for each therapy discipline provided. The therapy summary may be provided using the multidisciplinary conference notes or other documentation that meets this requirement.
6. Rehabilitation nursing summary documenting nursing services provided. The nursing summary may be provided using the multidisciplinary conference notes or other documentation that meets this requirement.

**CRITERIA MANUAL CHAPTER 6.0**  
**CRITERIA FOR OBSTETRIC AND NEWBORN SERVICES**

**CRITERIA MANUAL CHAPTER (6.1)**

**ACUTE OBSTETRIC INPATIENT SERVICES  
IN CONTRACT HOSPITALS IN CLOSED AREAS OR CONTRACT/NON-CONTRACT  
HOSPITALS IN OPEN AREAS**

- I. Obstetric inpatient care for a Medi-Cal eligible mother is covered by the Medi-Cal program in accordance with Title 22, California Code of Regulations, Section 51327 (a) (1) (A).
- II. In contract hospitals in closed areas or contract/non-contract hospitals in open areas, inpatient delivery services are covered without authorization up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted. Continued medically necessary hospitalization beyond two days prior to delivery requires timely submission of a request for authorization, as defined in Title 22, CCR, Section 51003, for Medi-Cal field office review. If delivery does not occur during the current hospital stay, authorization is required for all days of hospitalization. Authorization shall be based upon a determination of medical necessity. Such medical necessity justification shall include, but not be limited to, one of the following:
  - A. Active management of labor and delivery.
  - B. Persistent vaginal bleeding.
  - C. Premature rupture of membranes with continuing leakage of amniotic fluid, or meconium stained fluid.
  - D. Acute medical condition such as presence of shock symptoms, toxemia, or acute exacerbation of a preexisting medical condition such as diabetes, heart disease, pulmonary insufficiency, renal failure, thyrotoxicosis, hypertension, etc.
  - E. Signs of fetal distress or varying fetal heart tones.
  - F. Premature labor (less than 36 weeks' gestation).
  - G. Attending physician's medical concerns, not specified above, where the medical need for acute level of care is substantiated.
- III. Inpatient delivery services in hospitals designated as contract hospitals in closed areas or contract/non-contract hospitals in open areas are covered without authorization up to a maximum of 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean section. Continued necessary hospitalization beyond 48 hours following vaginal deliveries, or 96 hours following delivery by Cesarean section requires timely submission of a request for authorization for Medi-Cal field office review. Authorization shall be based upon a determination of medical necessity. Medical necessity for acute inpatient care may be demonstrated by an acute medical condition, including but not limited to, presence of shock symptoms, toxemia, acute sepsis, or an acute exacerbation of a preexisting medical condition such as diabetes, heart disease, pulmonary insufficiency, renal failure, thyrotoxicosis, or any other condition where the need for an acute level of care is substantiated.

- IV. A level of care other than acute inpatient care may be authorized for those conditions which, in the opinion of the Medi-Cal consultant, require continued hospitalization at a lower level of care, including continuing bed rest for stable patients requiring observation only. Such conditions may include, but not be limited to, the following:
  - A. Amniotic fluid leakage without active labor.
  - B. Pre-term labor without signs of significant progression.
  - C. Other medical conditions, which warrant continued hospitalization.
  
- V If delivery occurs prior to admission of the mother to the hospital, inpatient care for both the mother and newborn shall be covered without authorization up to a maximum of 48 hours beginning at midnight at the end of the day the mother delivers vaginally. The actual time of the vaginal delivery shall be established based on the mother's statement, records of auxiliary personnel involved in the care/transport of the mother, and clinical assessment by the attending physician.

**CRITERIA MANUAL CHAPTER (6.2)**

**INPATIENT NEWBORN SERVICES**

- I. Hospital care for newborns is covered by the Medi-Cal program in accordance with Title 22, California Code of Regulations (CCR), Section 51327 (a) (1) (B).
- II. Referral to the California Children Services (CCS) program for case management, as required by Title 22, CCR, Section 51013, shall be made when a child has a CCS- eligible condition, as defined in Title 22, CCR, Section 41800.
- III. If delivery occurs prior to admission of the mother to the hospital, inpatient care for both the mother and newborn shall be covered without authorization up to a maximum of 48 hours beginning at midnight at the end of the day the mother delivers vaginally. The actual time of vaginal delivery shall be established based on the mother's statement, records of auxiliary personnel involved in the care/transport of the mother, and clinical assessment by the attending physician.
- IV. Neonatal intensive care for sick newborns, is covered subject to authorization by a Medi-Cal consultant. Authorization shall be based upon the following guidelines:
  - A. All hospital admissions, transfers, ambulance and other related services otherwise requiring authorization for neonatal intensive care within the first 24 hours of life are considered emergency services and should be processed in the same manner as all other emergency services.
  - B. After the first 24 hours of life, a transfer from one acute hospital to another which has the level of care necessary to meet the medical needs of the patient is to be processed as are all other transfers. See Chapter 12.1, Criteria for Medical Transportation and Related Services.
- V. The majority of neonatal intensive care services are for the treatment of acute neonatal respiratory problems, but this is *not* a requirement. Authorization for neonatal intensive care services is based upon medical necessity, demonstrated by:
  - A. The infant is dependent upon medical technology, e.g. a ventilator or umbilical artery catheter, that necessitates medical care services that are only available in an NICU.
  - B. The infant's birth weight is less than 1500 gms and/or whose gestational age is less than 32 weeks.
  - C. Any other medical condition which, in the opinion of the Medi-Cal consultant, warrants NICU care.

**CRITERIA MANUAL CHAPTER (6.3)**

**OBSTETRICAL AND DELIVERY SERVICES IN NONCONTRACT HOSPITALS  
IN CLOSED AREAS**

- I. Hospital admissions to noncontract hospitals in closed areas for obstetrical delivery services require authorization. Approval shall be granted for only those obstetrical delivery services that meet the definition of emergency, as found in Title 22, CCR, Section 51056.
- II. The professional judgement of the Medi-Cal consultant will be utilized to designate obstetrical delivery services as emergency for the purpose of approving Medi-Cal authorization within noncontract hospitals in closed areas. The following are factors to be considered by the Medi-Cal consultant when making a determination if a female patient qualifies as an emergency obstetrical delivery patient. Pregnant females meeting one or more of the following criteria may be considered an obstetrical delivery emergency. These criteria include, but are not limited to:
  - A. Active vaginal bleeding (not bloody show) or the presence of shock symptoms.
  - B. Signs of fetal distress or variable fetal heart rate, rhythm, or tones;
  - C. Premature or prolonged rupture of membranes:
    1. There is a floating vertex or non-vertex presentation.
    2. There is evidence of third trimester herpes simplex.
    3. There is meconium stained amniotic fluid.
  - D. Toxemia (severe hypertension and/or convulsions).
  - E. Active labor with a significant medical illness: e.g., diabetes, heart disease, pulmonary insufficiency, renal failure, thyrotoxicosis, or AIDS/HIV seropositivity.
  - F. Premature labor (less than 36 weeks' gestation).

- G. Ectopic pregnancy or incomplete abortion.
- H. Signs and symptoms of, or at clinically significant risk of infection, sepsis, or septic shock.
- I. Active labor and unable to sustain transport to a contracting facility.
- J. Persistent, sustained abnormal maternal vital signs taken at rest.
- K. Any other clinical condition, which in the professional judgment of the Medi-Cal consultant, meets the regulatory definition of an emergency medical condition.

**NOTE:** When stable, the mother and infant, if delivered, shall be transferred to a contracting facility.

**CRITERIA MANUAL CHAPTER (6.4)**

**COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)**

**I. Medi-Cal Regulations**

Title 22, California Code of Regulations, Section 51348

**II. General**

Comprehensive perinatal services are covered subject to the requirements specified in the above regulations. Nutrition, psychosocial, or health education services in excess of the basic allowance may be authorized when, based on the comprehensive perinatal provider's documentation, additional services are medically necessary. The request for additional services shall include goals, number of visits requested and frequency of visits planned.

Justification will include documentation of:

- A. The high risk factor(s),
- B. The reason that the basic services already provided were not sufficient to deal adequately with the problem, and
- C. The nature of the proposed additional services.

**III. High Risk Factors**

High risk factors may include, but are not limited to the following:

- A. Preexisting medical conditions, e.g.,
  - 1. Family history of genetic disease
  - 2. Hereditary or congenital abnormality
  - 3. Exposure to teratogens
  - 4. Renal disease
  - 5. Cardiovascular disease
  - 6. Diabetes mellitus
  - 7. Epilepsy
  - 8. Cancer
  - 9. Severe anemia
  - 10. Asthma with persistent symptoms
  - 11. Morbid obesity
  - 12. Psychosis
  - 13. Mental disorders including mental retardation and developmental delay



14. Acute gastrointestinal disease
15. HIV/AIDS seropositivity
- B. Preexisting social problems, e.g.,
  1. Substance abuse
  2. Neglect/Abuse/Molestation
  3. Poverty
  4. Recent immigration from underdeveloped country
  5. Domestic violence
  6. Homelessness
- C. Problems with prior pregnancies, e.g.,
  1. Preterm/post term delivery. Premature labor
  2. Spontaneous or missed abortions
  3. Congenital anomaly
  4. Stillbirth
  5. Placental abnormalities
  6. Breech presentation
  7. Sibling SIDS
  8. Very low birth weight (<1500 grams) delivery
- D. Pregnancy-concurrent conditions, e.g.,
  1. Maternal age less than 17 years or older than 35 years
  2. Diabetes
  3. Hypertension
  4. Infectious disease likely to affect fetus (toxoplasmosis, CMV, malaria, exanthemous disease, listeriosis, herpes, AIDS/HIV seropositivity, etc.)
  5. Severe trauma
  6. Weight gain abnormalities
- E. Complications of pregnancy, e.g.,
  1. Clinically significant anemia
  2. Toxemia (Preeclampsia)
  3. Placenta previa
  4. Abruptio placentae
4. Multiple pregnancy

- 6 Nutritional disorders requiring medical nutrition therapy
  7. Intrauterine growth retardation
- F. Postpartum Conditions
1. Fetal/infant demise
  2. Ineffective infant attachment
  3. Nutritional status requiring medical nutrition therapy
  4. Difficulty with breast feeding

**CRITERIA CHAPTER 7.0**

**CRITERIA FOR LONG-TERM CARE SERVICES**

**CRITERIA FOR LONG-TERM CARE SERVICES****SKILLED NURSING FACILITY SERVICES****I. Criteria for Determining Admission to SNFs**

Criteria for admission to SNFs are contained in state regulations (Title 22, CCR, Section 51335) and are applied on a statewide basis. Those criteria for admission and extension of stay (continuing care) are as follows:

- A. Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician
- B. Need for constantly available skilled nursing services. A patient may qualify for SNF services if the patient's care involves one or more of the following conditions:
  - 1. Conditions such as the following weigh in favor of SNF placement:
    - a. Dressing of postsurgical wounds, decubitus ulcers, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require SNF care.
    - b. Tracheostomy care, nasal catheter maintenance.
    - c. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for SNF placement.
    - d. Gastrostomy feeding or other tube feeding.
    - e. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care where such is feasible for the patient. Colostomy care alone should not be a reason for continuing SNF placement.
    - f. Bladder and bowel training for incontinent patients.
  - 2. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a SNF depending on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in an SNF.
    - a. Regular observation of blood pressure, pulse, and respiration as indicated by the diagnosis or medication and ordered by the attending physician.
    - b. Regular observation of skin for conditions such as decubitus ulcers, edema, color, and turgor.
    - c. Careful measurement of intake and output as indicated by the diagnosis or medication and ordered by the attending physician.

3. If the patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications, SNF placement may be appropriate for reasons such as the following:
  - a. Injections administered during the evening or night shift. If this is the only reason for SNF placement, consideration should be given to other therapeutic approaches or to the possibility of teaching the patient or a family member to give the injections.
  - b. Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented.
  - c. Use of restricted or dangerous drugs if required more than during the daytime, requiring close nursing supervision.
  - d. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities (ICFs).
4. A physical or mental functional limitation.
  - a. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of ICFs.
    - (1) Bedfast patients.
    - (2) Quadriplegics or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in SNF.
    - (3) Patients who are unable to feed themselves.
    - (4) Patients who require extensive assistance with personal care such as bathing and dressing.
  - b. Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation) when such patients are severely incapacitated by mental illness or mental retardation. The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to the patient's mental condition.
    - (1) The severity or unpredictability of the patient's behavior or emotional state.
    - (2) The intensity of care, treatment, services, or skilled observation that the patient's condition requires and
    - (3) The physical environment of the facility, its equipment, and the qualifications of staff and
    - (4) The impact of the particular patient on other patients under care in the facility.

- c. The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

## II. Continuing Care Determinations

### A. Regular Extensions

Extensions of stay in SNFs require reauthorization by the Medi-Cal consultant every four months except for those patients who have been identified as "prolonged care" patients (see B, below). Regular extensions are based on the same criteria as initial authorizations.

### B. Prolonged Care Determinations

The "prolonged care" classification recognizes that the medical condition of selected patients requires a prolonged period of skilled nursing care. The prolonged care classification is intended only to eliminate unnecessary, costly paper work for both the State and providers of service. Reauthorizations for prolonged care at the SNF level of care are approvable for up to one year. Therefore, all patients are considered regular or nonprolonged care *unless* the patient meets the criteria for prolonged care.

Medical functional factors of the patient must support a sound professional judgment that a prolonged period of care will be required. The following medical/functional factors shall be used to reach the decision on prolonged care status:

1. Highest indications of need for prolonged care.
  - a. Total or severe incontinence which despite bowel and bladder training has failed to improve.
  - b. Bedridden and/or comatose or semicomatose states.
  - c. Conditions which have resulted in quadriplegia, hemiplegia, spasticity, rigidity, and uncontrolled movements, tremors, or deformity dependent upon severity or intensity
  - d. Conditions which require a high degree of prolonged medical nursing support and supervision (depending upon the patient's ability to participate responsibly in the patient's own care). These include complex regimens of oral and/or parenteral medications and diet to control diabetes, cardiac conditions, seizure disorders, hypertension, tumor conditions, obstructive pulmonary conditions, infectious conditions, and pain.
  - e. Conditions which require a high degree of prolonged mechanical nursing support and supervision (depending upon the patient's ability to participate responsibly in the patient's own care). These include tracheostomies, gastrostomies, colostomies, catheters, N/G tubes, IPPB machines, irrigation procedures, medicinal installation procedures, dressing changes, and conditions requiring sterile technique.

- f. Conditions requiring medical/psychiatric/developmental nursing support and supervision (dependent upon severity and the patient's ability to participate responsibly in the patient's own care). These include *extreme* confusion and disorientation, inability to communicate, unacceptable physical, sexual, or verbally aggressive behavior, and anxiety or depression which is secondary to the medical/physical condition (e.g., terminal cancer).

Note: Conditions which are psychogenic as opposed to organic are generally considered transitory in nature. They constitute poor justification for authorizing prolonged care.

2. Important indications of need for prolonged care. (Usually requiring two or more of the following factors.)

- a. Conditions outlined in c, d, e, and f above, but of lesser severity, intensity, or degree than alluded to in section 1, above.
- b. Occasional incontinence—on bowel and bladder retraining programs.
- c. Debilitating conditions including extreme age which indicate a need for preventive nursing care and supervision to avoid skin breakdown, fractured bones, nutritional deficiency, or infectious conditions.
- d. Cases in which the documented history gives clear indication that changes in the "status quo" will likely lead to levels of care which are more costly to the Medi-Cal program.

3. Supporting indications.

(The relative importance of factors in this category is determined by the relationship with factors from a and b of 1 above. Any one factor in this category *standing alone* is *not* sufficient to establish prolonged care status. However, items in this category will add to the weight of facts to support a finding of prolonged care status.)

- a. Conditions outlined in a and b of 1 above but of lesser severity, intensity, or degree than alluded to in those sections.
- b. Cases in which the documented history and/or diagnosis gives clear indication of progressive incapacitation.
- c. Dependence for activities of daily living—dependent upon degree.
- d. Sensory impairment.
- e. Generalized weakness or feebleness.
- f. Behavioral management problems.

### III. Subacute Level of Care—Criteria for Determining Admission or Extension of Stay (Continuing Care).

Subacute level of care is defined in Title 22, California Code of Regulations (CCR), Section 51124.5. Authorization shall be based on medical necessity and the lowest cost service in accordance with Title 22, CCR, Sections 51003 and 51303.

An initial Treatment Authorization Request shall be required for each admission. Extensions of stay require reauthorization by the Medical Consultant every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations.

Minimal standards of medical necessity for this 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. The need for special medical equipment and supplies such as ventilators which are in addition to those listed in Title 22, CCR, Section 51511(b).
- D. Twenty-four hour nursing care by a registered nurse.
- E. Any one of the following three items:
  - (1) A tracheostomy with continuous mechanical ventilation for at least 50 percent of the day; or
  - (2) Tracheostomy care with suctioning and room air mist or oxygen as needed and one of the six treatment procedures listed in Section F; or
  - (3) Administration of any three of the six treatment procedures listed in Section F.
- F. Treatment Procedures
  - 1. Total parenteral nutrition (TPN).
  - 2. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week.
  - 3. Tube feeding (NG or gastrostomy).
  - 4. Inhalation therapy treatments during every shift and a minimum of 4 times per 24-hour period.
  - 5. 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.
  - 6. Debridement, packing, and medicated irrigation with or without whirlpool treatment.



**INTERMEDIATE CARE FACILITY SERVICES****I. Criteria for Determining Admission to ICFs**

Criteria for admissions to ICFs are contained in state regulations (Title 22, CCR, Section 51334) and are applied on a statewide basis. Those criteria for admission and extension of stay (continuing care) are as follows:

To qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate deterioration. ICF services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encourage each patient's independence to the extent of the patient's ability. As a guide in determining the need for ICF services, the following factors are considered in determining appropriate placement:

- A. The complexity of the patient's medical problem is such that the patient requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet the patient's health needs.
- B. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or frequent doses of PRN narcotics may not qualify.
- C. Diet may be of a special type, but patient needs little or no assistance in feeding himself.
- D. The patient may require minor assistance or supervision in personal care such as in bathing or dressing.
- E. The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.
- F. The patient may have some degree of vision, hearing, or sensory loss.
- G. The patient may have some limitation in movement but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.
- H. The patient may need some supervision or assistance in transferring to a wheelchair but must be able to ambulate the chair independently.
- I. The patient may be occasionally incontinent of urine; however, a patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and is capable of self-care.
- J. The patient may exhibit some mild confusion or depression; however, the patient's behavior must be stabilized to such an extent that it poses no threat to self or others.

**II. Continuing Care Determinations**

**A. Regular Extensions**

Extensions of stay in ICFs require reauthorization by the Medi-Cal consultant every four months except for those patients who have been identified as prolonged care patients (see B, below). Regular extensions are based on the same criteria as initial authorizations.

**B. Prolonged Care Determinations**

The "prolonged care" classification recognizes that the medical condition of selected patients requires a prolonged period of intermediate nursing care. The prolonged care classification is intended only to eliminate unnecessary, costly paper work for both the State and providers of service. Reauthorizations for prolonged care at the ICF level of care are approvable for up to six months.

**INTERMEDIATE CARE FACILITY SERVICES FOR DEVELOPMENTALLY  
DISABLED (ICF/DD) AND INTERMEDIATE CARE FACILITIES FOR  
DEVELOPMENTALLY DISABLED HABILITATIVE (ICF/DDH)**

**I. Criteria for Determining Admission to ICFs/DD**

Criteria for admissions to ICFs/DD are contained in state regulations (Title 22, CCR, Section 51343) and are applied on a statewide basis. The criteria for admission are as follows:

- A. To qualify for ICF/DD services, persons shall meet the definition for developmental disability as defined in Title 22, CCR, Section 51164.**
- B. Services are limited to those persons who require and will benefit from services provided pursuant to the provisions of Sections 76301 through 76413. In determining the need for ICF/DD services, the following criteria shall be considered:**
  - 1. The complexity of the patient's medical problems is such that the patient requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet the patient's health needs.**
  - 2. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.**
  - 3. The extent of the patient's psychosocial and developmental service needs shall be determined.**
  - 4. The patient's need for specialized developmental, training, and habilitative program services which are not available through other levels of care shall be determined.**
  - 5. The extent to which provision of specialized developmental, training and habilitative program services shall be determined as to how they can reasonably be expected to result in a higher level of functioning and lessening dependence on others in carrying out daily living activities.**
  - 6. The patient shall have a qualifying developmental deficit in either a self-help area or social-emotional area as follows:**
    - a. A qualifying developmental deficit shall be determined in the self-help skill area if the patient has two moderate or severe skill task impairments from a combination of the following defined assessment items:**
      - (1) Eating**
        - (a) Does not feed self, requires assistance.**
        - (b) Attempts to feed self with fingers or spoon, but may require assistance.**

- (2) Toileting
    - (a) Not toilet trained or habit trained.
    - (b) Is habit trained.
    - (c) Indicates need to toilet self, but requires assistance.
    - (d) Goes to toilet by self, but requires assistance to complete toileting.
  - (3) Bladder Control
    - (a) No bladder control.
    - (b) Some bladder control, occasional accidents during waking hours (once a week or more)
    - (c) Wets bed at night.
  - (4) Dressing
    - (a) Does not dress.
    - b) Puts on some clothes by self, or assists when being dressed.
- b. A qualifying developmental deficit shall be determined in the social-emotional area if the patient exhibits two moderate or severe impairments from a combination of the following defined assessment items:
  - (1) Social behavior, including but not limited to stealing, excessive screaming, teasing, lying, hugging, etc.
    - (a) Participation in group activities is often prevented or disrupted by unacceptable social behavior.
  - (2) Aggression
    - (a) Has had violent episodes which have caused serious physical injury in past year.
    - (b) Has had violent episodes which have caused minor physical injury in past year.
    - (c) Has not caused physical injury in past year, but often resorts to verbal abuse and threats.

- (3) Self-injurious behavior, including but not limited to biting, scratching, putting inappropriate objects into ear, mouth, etc.
  - (a) Self-injurious behavior causes severe injury which requires physician attention at least once per year.
  - (b) Self-injurious behavior requires first aid at least once a month or self-injurious behavior which requires physician attention at least once per year.
- (4) Smearing
  - (a) Smears at every opportunity.
  - (b) Smears at least once a week.
  - (c) Smears but does so infrequently
- (5) Destruction of Property
  - (a) Serious property damage has occurred at least once in the past year.
  - (b) Minor property damage has occurred twice or more in the past year.
- (6) Running or Wandering Away

Running or wandering away occurs at least monthly unless prevented.
- (7) Temper Tantrums or Emotional Outbursts

Temper tantrums are displayed at least once a month.

## II. Criteria for Determining admission to ICFs/DDH

Criteria for admission to ICFs/DDH are contained in state regulations (Title 22, CCR, Section 51343) and are applied on a statewide basis.

- A. To qualify for ICF/DDH services, persons shall meet the definition for developmental disability as defined in Title 22, CCR, Section 51164.
- B. Services are limited to those persons who require and will benefit from services provided pursuant to the provisions of Title 22, CCR, Sections 76853 through 76906.
- C. In determining the need for ICF/DDH services, the criteria in Part I, ICF/DD Services, apply except that patients shall not have any of the following developmental deficits in the socio-emotional area:
  - 1. Aggression—has had violent episodes which have caused serious physical injury in past year.

2. Self-injurious behavior--causes severe injury which requires physician attention at least once per year.
  3. Smearing--smears at every opportunity.
- D. Patients shall not be admitted to or approved for services if these patients:
1. Have decubitus ulcers.
  2. Require restraints, except as provided in Title 22, CCR, Sections 76867 and 76868.

**CRITERIA MANUAL CHAPTER 9.1****CRITERIA FOR HOME HEALTH AGENCY SERVICES****I. MEDICAL REGULATIONS**

Title 22, CCR, Sections 51003, 51125, 51129, 51146, 51217, 51337, 51455, 51523.

**II. GENERAL**

Home health agency (HHA) services are covered subject to the requirements specified in the above regulations in the following two general situations:

- A. During the convalescent phase of posthospital or institutional discharge or during the convalescent phase following an acute episode or exacerbation of an illness of a homebound patient.
- B. When the homebound patient (Section 51146) can be maintained at home in lieu of institutional placement with skilled nursing or other care. Unlike Medicare, Medi-Cal does not require that the patient receive any particular therapeutic service as a prerequisite for any other therapeutic service.

**NOTE:** When the overall continuing care (long-term) of an HHA would exceed the monthly cost of maintaining this patient in a board and care, intermediate care, or nursing home, consideration must be given to requiring institutional placement unless overriding social considerations mitigate against such placement or the patient is consistently rejected by long-term care facilities.

Restorative or rehabilitation services will be terminated when the patient's condition has plateaued and no significant medical need exists or no significant functional benefit will be achieved by continued treatment or therapy. It is expected that continued services reflecting a need for minimal professional skill such as passive range of motion, assistance with ambulation, and/or routine activities of daily living will be carried out by the patient, family, or others.

Home health aide services will not be provided where such services more appropriately fall within the purview of homemaker or attendant care services provided through the county welfare department.

**C. The Treatment Plan**

- 1. Specific services may be authorized only after being prescribed by a physician as to the extent and duration of the service(s), Title 22 (Section 51129), and in accordance with a written treatment plan in Title 22 (Section 51337). The treatment plan must be reviewed by a physician every 60 days.
- 2. The treatment plan will include a need for one or more covered services such as skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social worker, home health aide, and appropriate medical supplies not to include drugs and biologicals.

#### D. TAR Completion

1. TARs may be authorized for a maximum of 30 visits; TARs may be valid for up to one year. TARs should be completed using the five-digit SMA code and HHA's usual and customary charge for the requested service.
2. The TAR must be accompanied by the plan of treatment and the signed physician prescription (order). TARs also require the prescribing physician's Medi-Cal provider number. The plan of treatment must clearly indicate that the patient is homebound and, if home health aide services are requested, whether assistance from household members or others is available.

#### E. Services covered by Medi-Cal

##### 1. Skilled Nursing

Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse. Services include evaluation visits, observation, monitoring, training, and other services requiring substantial specialized nursing skill.

##### 2. Home Health Aide

Services given in accordance with the treatment plan and under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Services include assisting the patient with personal care, bathroom needs and ambulation, and performing medically necessary household services to facilitate the patient's self-care such as changing the bed and light cleaning.

##### 3. Physical Therapy

Services given to relieve pain, restore bodily functions, instruct in development of an exercise program, and to introduce the use of special rehabilitative devices.

##### 4. Occupational Therapy

Services designed to assist the patient in developing functional and creative activities leading to maximum self-care and adjustment to daily living.

##### 5. Speech Therapy

Services which assist the patient in regaining speech abilities that have been impaired following an illness or accident.

##### 6. Medical Social Services

Services are covered which deal with social, economic, and emotional factors related to illness. General social services, which are not medically related, are not reimbursable under Medi-Cal. *Referral* to community resources may be reimbursable if provided in connection with medically indicated therapy or counseling.



## 7. Case Evaluation and Initial Treatment Plan

One visit in a six-month period per patient for the purposes of evaluation is reimbursable without prior authorization. The "evaluation visit" includes one service (treatment) visit and the charge for writing a case evaluation and treatment plan. If another case evaluation is requested within the six-month period, it will be granted only if there is a significant change in the patient's condition or family situation which requires writing a new individual treatment plan.

## 8. Monthly Case Evaluation

A monthly case evaluation (report) is for the purpose of reviewing and, if necessary, revising the patient treatment plan. Monthly evaluations are warranted when there is a significant change in the patient's living situation or condition or the patient's treatment plan involves frequent services or a variety of services over a period of time. Monthly evaluations would not be appropriate where the treatment plan is of short duration or the patient's condition is static.

### F. Unlisted Services

These services include medical supplies which are left with the patient as part of the treatment plan. Medical supplies which are routinely used in connection with service visits are not separately payable. Unlisted services also include unusual transportation expenses. These items must be billed "by report" and reflect actual cost.

### G. Noncovered Services

Medi-Cal will not reimburse HHAs for any of the following: physician services, nutritionist services, podiatrist services, drugs, and biologicals.

## III. STATUS OF PATIENT

- A. In all cases the patient requiring HHA services must have a medical condition requiring skilled care so as to prevent further disability and/or promote improvement.
- B. The patient's medical condition(s) for which services are being prescribed must be reasonably responsive to the prescribed service(s). This can be determined with reference to:
  1. The type of the medical condition.
  2. The duration of the medical condition.
  3. The history of previous services and the result of such services.
  4. The chronicity and/or exacerbation state of the medical condition.
- C. The nature and/or severity of the medical condition(s) should be such that the patient meets one or more of the following conditions:

1. Not reasonable for the patient to go to the provider's office, clinic, or hospital to obtain the needed service(s).
  2. Unable to give self-care due to the limitations of the medical condition and/or the complexity of the service(s) or unable to comprehend and follow through on self-care.
  3. Unable to have a relative/associate in the home or area who is sufficiently knowledgeable to aid in providing the services(s).
  4. The term "homebound" as applied to the patient in the guidelines is defined in Title 22, CCR, Section 51146, as a beneficiary who is essentially confined to his/her home due to illness or injury and if ambulatory or otherwise mobile, is unable to be absent from his/her home except on an infrequent basis or for periods of relatively short duration, e.g., a short walk prescribed for therapeutic exercise.
- D. The patient's medical condition for which restorative services are prescribed must be one for which reasonable goals of stabilization and/or improvement can be defined.

The status of the patient as defined in this section applies to all medical conditions outlined in Section IV.

#### IV. MEDICAL CONDITIONS

The following guidelines set forth generally acceptable types and volume of services for some of the more common medical conditions leading to a need for HHA care. They are formulated on the basis of, but do not require, a 60-day period of service. Frequency of the service visits will vary depending on the nature and changing status of the patient's medical condition. The guidelines do not require or make mandatory authorization for any specific services or volume or duration or frequency of such services in an individual case. Appeal of consultant decisions are provided for in regulation. Although the guidelines are written in respect to a 60-day period, in an individual case, only a few visits over 14 days to 30 days may be required. In some circumstances the number of visits planned and considered reasonable in reference to a case may be authorized to the provider over a longer period.

The guidelines for services for the following medical conditions are medically reasonable but in no way are required or mandatory with respect to the type of service(s), number of service visits, duration of visits, or frequency of visits in an individual case.

The medical consultant is still responsible for authorization of the type and volume and duration of any service(s) felt to be medically necessary in the individual case. When presented with additional information, the medical consultant may grant additional service(s) as to type, duration, and volume of visits in the individual case within the limits of the regulations. Conversely, the consultant may authorize fewer services depending on the severity of the patient's condition.

The number of service visits in the guidelines apply to an average 60-day period but in no way is a 60-day period of service required or mandatory. The figures in parentheses refer to the number of service visits.

A. Arthritis

1. Clinical Findings

Date of onset of severe arthritis condition which:

- a. As a result of the arthritis condition and/or associated medical conditions renders the patient homebound.
- b. Description and date of any definite exacerbation of an arthritis condition in such a homebound case.

2. Services

- a. Skilled Nursing Care (2-8).
- b. Physical Therapy (12-16).
- c. Occupational Therapy (12-16); depending on the location of the arthritic involvement occupational therapy may be more pertinent than physical therapy. An example is in cases where there is hand involvement.
- d. Medical Social Worker (1-2) if clinically applicable to aid in social adjustment to severity of the disease and for community resource referral.
- e. Home Health Aide (16-24).

3. Goals

- a. Reasonable stabilization of the medical condition.
- b. Improve self-care and activities of daily living such as dressing and toileting.
- c. Aid in adjustment to the limitations of the arthritis condition.
- d. Orientation to appropriate therapy programs.

4. Monthly Case Evaluation (1-2)

B. Cancer

***Nonterminal***

1. Clinical Findings

- a. Date of onset of newly diagnosed condition or exacerbation and in
- b. Homebound status due to cancer and/or associated medical condition and/or
- c. Requires intravenous chemotherapy treatments and/or
- d. Dysphagia may require nasogastric tube feedings and/or

- e. May require urinary catheter drainage.

## 2. Services

- a. Skilled Nursing Care (4-16).
- b. Occupational Therapy (2-6) as clinically applicable, e.g., mastectomy patient in need of upper extremity exercise program.
- c. Speech Therapy (14-16) as clinically applicable, e.g., immediate post glossectomy or laryngectomy case.
- d. Medical Social Worker (2-3) if clinically applicable for emotional support for patient and family/associates and mobilize community resources.
- e. Physical Therapy (2-6) as clinically applicable, e.g., spinal cord tumor with lower extremity weakness.
- f. Home Health Aide (12-16).

## 3. Goals

- a. Reasonable stabilization of the medical condition and
- b. Improve self-care and orient relatives/associates in case.
- c. Complete any required intravenous chemotherapy regime.
- d. Aid in mobilizing community resources as required, e.g., welfare benefits, "meals on wheels", and caretaker help.

## 4. Monthly Case Evaluation (1-2)

### ***Terminal***

#### 1. Clinical Findings

- a. Severe generalized debilitated physical condition due to cancer with
- b. Progressive reduction in nutrition/hydration status and/or
- c. High risk for skin and other complications such as intercurrent infection and/or
- d. Pain control frequently necessary.
- e. Family members require counseling regarding patient care and planning.

## 2. Services

- a. Skilled Nursing Care (12-16).
- b. Physical Therapy (4-6).
- c. Occupational Therapy (4-6).
- d. Medical Social Worker (2-3) if clinically applicable for emotional support of the patient and family/associates. To aid in planning possible hospice status and a plan for death.
- e. Home Health Aide (16-24).

## 3. Goals

- a. Maintain reasonable nutrition/hydration of patient.
- b. Prevent complications such as decubiti and intercurrent infections.
- c. Supervise pain and other medication as necessary.
- d. Orient family/associates of patient to care and management.
- e. Support of family/associate members.

## 4. Monthly Case Evaluation (1-2)

### C. Cardiovascular Conditions

#### 1. Clinical Findings

Date of onset of severe cardiac or vascular condition which alone or in combination with associated medical conditions requires patient to be homebound such as in cases of:

- a. Newly diagnosed severe congestive heart failure with chronic dyspnea, edema, and weakness or
- b. Newly diagnosed postmyocardial infarction, severe, with heart failure component.
- c. Severe recurrent angina not responsive to medical, surgical, or other therapy.
- d. Newly diagnosed congestive heart failure in a patient who has another severe medical condition such as residuals of cerebrovascular accident with hemiplegia.
- e. Newly diagnosed hypertensive cardiovascular disease with associated severe mental dysfunction and/or associated medical conditions making transportation impractical.

- f. Newly diagnosed severe thrombophlebitis of one or both lower extremities, frequently on anticoagulant treatment.
- g. History of cardiac arrhythmias which require close monitoring.

**2. Services**

- a. Skilled Nursing Care (10-14).
- b. Physical Therapy (4-6) as clinically applicable, e.g., to orient and reinforce cardiac rehabilitation program.
- c. Occupational Therapy (1-2) as clinically applicable, e.g., to orient patient to new work simplification and energy conservation programs.
- d. Medical Social Worker (2-3) as clinically indicated, e.g., to aid in orientation to new occupational endeavors, to altered body image, to sexual adjustment, and in family supportive effort.
- e. Home Health Aide (12-24).

**3. Goals**

- a. Promote stabilization of cardiac or vascular condition by monitoring patient care and status.
- b. Orient patient and relatives/associates to medical condition, self-care, and medications.
- c. Orient patient toward an effective cardiac rehabilitation program if clinically applicable.
- d. Establish family/associate support for new medically required life style if necessary.
- e. Maintenance of chronic anticoagulation program.

**4. Monthly Case Evaluation (1-2)**

**D. Cataract - Postsurgery**

**1. Clinical Findings**

- a. Date of surgery of a newly operated postcataract patient who due to general medical/mental/physical condition, cannot himself/herself or have relatives/associates reliably follow up in the immediate postoperative period regarding observation of the eye, placement of required medication drops, and/or eye shield and
- b. The patient also is homebound due to associated medical conditions.

2. Services

- a. Skilled Nursing Care (8-12).
- b. Home Health Aide (3-8).

3. Goals

- a. Stabilize the postcataract surgical condition.
- b. Orient the patient and/or family/associates to self-care concerning postcataract care.

4. Monthly Case Evaluation (none required)

E. Diabetes Conditions

***Diabetes -- New Case Requiring Injectable Insulin***

1. Clinical Findings

- a. The case must be newly diagnosed and/or newly on insulin by injection and in need of teaching regarding perception or use of basic information concerning diet, administration of insulin injections, urine tests, and overall self-care and
- b. The patient is homebound due to the diabetic medical condition and/or associated medical conditions.
- c. The patient has longstanding diabetes but presents continuing problems of control.

2. Services

- a. Skilled Nursing Care (10-14).
- b. Medical Social Worker (1-2) if clinically applicable, e.g., to aid in adjustment to new limitations of the diabetic medical condition.
- c. Home Health Aide (10-12).

3. Goals

- a. Orientation of patient and/or relatives/associated to proper medical regime of diet, insulin preparation and injections, urine and/or blood testing, and general self-care.
- b. Basic adjustment of the patient to the limitations of the new diabetic medical condition.

4. Monthly Case Evaluation (none required)

***Diabetes -- Blind***

**1. Clinical Findings**

- a. Patient requires injectable insulin and cannot see to fill syringes and
- b. No family member/associate is available to aid in a regular way regarding the injectable medication.

**2. Services**

- a. Skilled Nurse (4, e.g., 1 visit every 2 weeks).
- b. Home Health Aide (4, e.g., alternate 1 visit with nurse every 2 weeks).

**3. Goals**

Maintenance of stable diabetic medical condition.

**4. Monthly Case Evaluation (none required)**

**5. Supplies**

Disposable syringes.

***Diabetes -- With Other Medical Conditions***

Such conditions are noted under cardiovascular, neurologic, or other appropriate headings in the guidelines.

**F. Hemodialysis Cases**

**1. Clinical Findings**

On-site visits to patient's home/dialysis center to evaluate:

- a. Overall medical/social condition of the patient and family/associate availability for support.
- b. Evaluation of the medical condition of the patient pre- and immediate postdialysis for planning requirement for nonemergency medical transportation from home to dialysis center and/or return.

**2. Services**

- a. Skilled Nursing Service (Evaluation) (1-2).
- b. Medical Social Worker (1-2) if more extensive social information is indicated as in 1.a above.



3. Goals

Evaluation of patient's medical and social condition for planning medically necessary care.

4. Monthly Case Evaluation (none required)

G. Medication Injections

1. Clinical Findings

Homebound cases of:

- a. Pernicious anemia and other B12 deficiency disorders requiring monthly maintenance B12 injections. May require multiple weekly injections in initial period and monthly when stabilized.
- b. Anemia requiring intermittent interferon injections.
- c. Tuberculous meningitis requiring a series of streptomycin injections.
- d. Infectious conditions such as osteomyelitis requiring a series of injectable antibiotics/medications.
- e. A newly anticoagulated case requiring a short series of injectable heparin or management of a heparin lock or longer series of low dose heparin injections.

2. Services

Skilled Nursing Care (2-16), but frequency and duration will depend on the specific condition.

3. Goals

- a. Maintenance of a stable medical condition such as pernicious anemia.
- b. Completion of a medical treatment regimen such as of streptomycin therapy for a tuberculous meningitis case.
- c. Completion of appropriate anticoagulant course and/or conversion to oral anticoagulant agent.

4. Monthly Case Evaluation (none required)

H. Neurological Conditions

***Cerebrovascular Accident and Other Neurological Conditions***

Includes progressive peripheral neuropathies such as parkinsonism, multiple sclerosis, and amyotrophic lateral sclerosis.

**1. Clinical Findings**

**Date of onset of newly diagnosed or recurrent cerebrovascular accident case where there is severe, continuing hemiplegia and/or aphasia and/or mental obtundation which alone or in association with other medical conditions renders the patient homebound.**

**2. Services**

- a. Skilled Nursing Care (12-16).**
- b. Physical Therapy (12-16) (or more) if clinically applicable and dependent upon extent and severity of any motor and sensory losses.**
- c. Occupational Therapy (12-16) (or more) if clinically applicable and dependent upon the extent of the limitation of function in the upper extremity and of any dysphagia. May replace some physical therapy.**
- d. Speech Therapy (8-24) (or more) if clinically applicable and dependent on the extent of the communication disorder.**
- e. Medical Social Worker (2-3) if clinically applicable regarding a definite need for counseling concerning adjustment to altered body image and life/work/school plans. To also aid in community resource mobilization.**
- f. Home Health Aide (16-24).**

**3. Goals**

**Stabilization and/or improvement of the medical condition regarding:**

- a. Self-care aspects, e.g., diet, medication, skin care, and bowel and bladder function.**
- b. Motor functions such as transfer, gait, and ambulation as needed.**
- c. Speech communication as clinically applicable and feasible.**
- d. Orientation to any required assistive devices.**
- e. Adjustment to altered body image and function.**
- f. Orientation and acquisition of community resources, e.g., "meals on wheels."**

#### 4. Monthly Case Evaluation (1-2)

##### ***Coma – Stupor States – Chronic***

#### 1. Clinical Findings

- a. Chronic coma states due to any cause where home care is feasible due to presence of responsible relatives/associates and desirable.
- b. Chronic coma-stupor state implies the usual problems regarding nourishment (tube feedings), skin care, at times tracheostomy care, bladder catheter drainage, rectal impaction problems, and as required medical and/or physical therapy.

#### 2. Services

Services are written in reference to a chronic, continuing care base but in a 60-day period as regards number of service visits. Frequency of services can still be arranged on an individual care basis.

- a. Skilled Nursing Care (4-8).
- b. Physical Therapy (4-8) if clinically applicable.
- c. Medical Social Worker (0-1) as social needs may indicate in reference to support needs of the relative/associate of the patient.
- d. Home Health Aide (8-24) as clinically indicated by the medical requirements of the patient.

#### 3. Goals

- a. Continued stabilization of a chronic medical case.
- b. Prevention of medical complications in a chronic medical case.
- c. Supervision and support of relatives/associates involved with a chronic case.

#### 4. Monthly Case Evaluation (1-2)

##### ***Paralysis – Quadriplegia and Paraplegia***

#### 1. Clinical Findings

- a. Patient is homebound due to a quadriplegic state of such a nature as to reasonably preclude any type of ambulation even with supportive devices.
- b. Patient is homebound due to a paraplegic state making ambulation even with supportive devices essentially unreasonable and impractical and/or the patient has other medical conditions which in combination with the paraplegia render the patient homebound.

- c. The cause of the paraplegia or quadriplegia may be due to trauma and also any medical condition to include the residuals of severe neuropathic disorders or spinal cord conditions such as amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's syndrome, or myasthenia gravis.
- d. Home care is feasible due to the presence of relatives/associates and desired.

## 2. Services

Services will depend on the status of the individual case, e.g., quadriplegic with tracheostomy and frequent bladder catheter complications or a case of moderately severe paraplegia with normal automatic bladder but who has moderate dementia.

- a. Skilled Nursing Care (4-16).
- b. Physical Therapy (4-16).
- c. Occupational Therapy (4-16) as clinically applicable as regards upper extremity dysfunction.
- d. Medical Social Worker (2-3) if clinically applicable to aid in adjustment to limitations of the medical condition, orientation to a new life style, and to garner community resources.
- e. Home Health Aide (8-24).

## 3. Goals

- a. Continued stabilization of a chronic medical case.
- b. Prevention of medical complications in a chronic medical care case.
- c. Supervision and support of relatives/associates involved with a chronic medical care case.
- d. Orientation and acquisition of community resources as required.
- e. Adaptation to the home environment including appropriate adaptive devices, movement around the home to manage own needs, and learn to use community resources in order to prevent institutionalization and/or reduce the need for long-term attendant care services.

## 4. Monthly Case Evaluation (1-2)

### ***Dementia -- Chronic***

#### 1. Clinical Findings

- a. The patient suffers from a moderately severe or greater degree of chronic dementia which precludes reasonable travel for maintenance medical care, even with an attendant, due to the severity of the mental state and/or associated medical conditions.

- b. The chronic dementia may be caused by any medical condition ranging from post traumatic effects to Alzheimer's disease.
- c. Home care is feasible and desired due to the presence of responsible relatives/associates.

## 2. Services

Services will depend on the status of the individual case, e.g., a patient with moderate or severe dementia without other medical problems or a patient with moderate or severe dementia with associated severe hypertensive cardiovascular disease with chronic moderate congestive heart failure. Cases with paralysis are noted under *Paralysis* area of guidelines.

- a. Skilled Nursing Care (2-8).
- b. Occupational Therapy (2-8) if clinically applicable.
- c. Medical Social Worker (1-2) if clinically applicable for emotional support of the patient and/or relatives/associates and to mobilize community resources.
- d. Home Health Aide (8-12).
- e. Physical Therapy (2-4) if clinically applicable.

## 3. Goals

- a. Continued stabilization of a chronic medical condition.
- b. Supervision and support of the patient and relatives/associates in regard to a chronic medical/mental case.
- c. Orientation and acquisition of community resources as required.

## 4. Monthly Case Evaluation (1-2)

### I. Newboms and Infants

#### 1. Clinical Findings

- a. The medical condition of the newborn or infant requires close medical follow-up and
  - (1) The mother's medical/mental condition is of such a nature as to require professional supervision and support to assure medically necessary newborn care or
  - (2) The type of medical care required is most reasonably and practically carried out by intermittent home visit.

b. Examples of such cases are:

- (1) A newborn with Down's syndrome and the mother is emotionally upset so that visits are required for child observation and orientation and counseling of the mother by a nurse and social worker.
- (2) An infant with tuberculous meningitis to be seen for injectable streptomycin drug therapy in a graduated series of skilled nursing care visits.
- (3) High risk infants from NICUs where bonding between mother and child may have been interfered with and where there is question as to parents' knowledge and ability to follow through with care. Will need observation in the home situation by skilled nurse.
- (4) Any care such as gavage feedings, sterile dressing changes, etc., which should be observed and where follow-up instruction may be necessary.
- (5) Early discharge (within 24 hours of birth) to monitor conditions of infant and mother. Check PKU.

2. Services

The status of the individual case will determine the services required and length of services. The guidelines are given for a 60-day period for an average type follow-up and observation of cases. Specific chemotherapy injection cases are not in the average and must be individualized.

- a. Skilled Nursing Care (8-24).
- b. Medical Social Worker (4-8) if clinically applicable to provide emotional supervision and support in case where the mother-child relationship is precarious for social as well as medical reasons.
- c. Physical Therapist (2-8).
- d. Occupational Therapist (2-8).
- e. Home Health Aide (8-10).

3. Goals

- a. For observation and counseling regarding medical status and care needs of newborn and infant.
- b. Supervision of ongoing medical care treatment of the newborn and infant.
- c. Orientation and counseling of the mother/associates of the infant for promotion of health and social adjustment.
- d. Orientation to and acquisition of community resources as required.

#### 4. Monthly Case Evaluation (1-2)

### J. Orthopedic Conditions

#### **Fractures**

##### 1. Clinical Findings

###### Require

- a. Date of recent fracture of back, pelvis, hips, or femur.
- b. Description of the type and extent of the fracture and of any associated medical conditions.
- c. Description of the extent of any surgical/medical treatment of the fracture as to type of cast, e.g., body or hip spica, and/or internal fixation and prognosis for expected weight bearing.
- d. The case must be recent, involving casting of such a nature and/or indicate a definite need for limited weight bearing so as to necessitate a homebound status during the initial phase of treatment.
- e. A case with fracture of the upper extremity(ies) must be of such severity or complexity and/or have associated medical conditions of such severity so as to render the patient homebound.

##### 2. Services

Services will depend on the status of the individual case as to extent of immobility, degree of casting, limitation regarding weight bearing, associated medical conditions, and presence of relatives/associates in the home.

- a. Skilled Nursing Care (4-8).
- b. Physical Therapy (8-12).
- c. Occupational Therapy (8-12) may be indicated if case involves upper extremity fracture, or to assist with self-care adaptations when there are lower extremity, pelvic, or spinal fractures.
- d. Medical Social Worker (1-2) if clinically applicable for community resource referral.
- e. Home Health Aide (12-24).

##### 3. Goals

- a. Orientation of patient and family/associates regarding personal self-care of the orthopedic and associated medical conditions.

- b. Prevention of medical complications, e.g., skin problems, infections.
  - c. Promote medical recovery and ambulation.
  - d. Orientation and acquisition of community resources as required.
4. Monthly Case Evaluation (1 or 2)

### ***Joint Replacements and Extremity Amputations***

#### **1. Clinical Findings**

- a. Date of total joint replacement of hip or knee in a case where limited and graduated weight bearing is prescribed and/or where associated medical conditions render the patient homebound.
- b. Date of total joint replacement of shoulder or elbow in a patient where associated medical conditions render the patient homebound.
- c. Date of amputation and description of extent and type in a patient who due to the severity of the amputation and/or age and associated medical conditions, is rendered homebound.

#### **2. Services**

- a. Skilled Nursing Care (8-16).
- b. Physical Therapy (8-16).
- c. Occupational Therapy (8-16) if clinically applicable.
- d. Medical Social Worker (1-2) if clinically and socially applicable for community resource referral.
- e. Home Health Aide (8-24).

#### **3. Goals**

- a. Observation for and prevention of postoperative complications.
- b. Establish physical therapy program with graduated ambulation and/or promote functional use of the involved extremity.
- c. Instruction regarding internal or external prosthesis use.
- d. Adjustment to altered body image and life style and aid in vocational rehabilitation referral.
- e. Orientation and acquisition of community resources as needed.



**4. Monthly Case Evaluation (0-2)****K. Ostomies****1. Clinical Findings**

- a. Date of placement of ostomy (gastrostomy, colostomy, ileostomy, cystostomy) in a patient who as a result of the basic medical condition requiring ostomy, e.g., cancer of the colon and severe weakness and/or due to associated medical conditions, is rendered homebound.
- b. Skin excoriation.
- c. Requires assistance with fitting of appliance.

**2. Services**

- a. Skilled Nursing Care (12-16).
- b. Social Work Services (2-4).
- c. Home Health Aide (16-24).

**3. Goals**

- a. Instruction of the patient and/or relative/associate so as to promote self-care of the ostomy and appliances.
- b. Adjustment to altered body image and function as a result of the ostomy.
- c. Assist with complications (fecal impaction, decubiti).

**4. Monthly Case Evaluation (1-2)****L. Respiratory Conditions****1. Clinical Findings**

- a. Date of onset and type and severity of pulmonary disease such as emphysema, asthma, or bronchiectasis and description of any associated medical conditions is required.
- b. Respiratory disease cases can be of acute severe resolving type or chronic severe type. In all cases, as a result of the respiratory conditions, the patient is rendered homebound.

**2. Services**

- a. Skilled Nursing Care (8-12).
- b. Occupational Therapy (1-4).

- c. Medical Social Worker (2-3) if clinically applicable to aid in the patient's adjustment to the limitations, severity, and chronicity of his/her condition.
  - d. Physical Therapist (8-24).
  - e. Home Health Aide (16-24).
3. Goals
- a. Orientation and supervision of patient and/or relatives/associates in reference to pulmonary toilet and if required, the use of oxygen, bronchodilators, postural drainage, respirator use, and tracheostomy care.
  - b. Orientation toward energy conservation and work simplification.
  - c. Orientation and acquisition of community resources as required.
4. Monthly Case Evaluation (1-2)
- M. Wound and Burn Conditions – Postsurgical or Due to Injury/Disease
1. Clinical Findings
- a. Date of onset of patient's recent, healing wound which is postsurgical or due to injury/disease which is of such an extent and/or due to associated complicating medical conditions that it renders the patient homebound for usually a temporary period.
  - b. Patient is homebound due to severe paralysis or other type of debilitating disease condition and has severe decubiti requiring home care.
  - c. Patient has extensive and severe degree of burn areas (greater than five percent and of second or third degree) which are healing and require home care until a satisfactory healing state has been attained.
- 2 Services
- a. Skilled Nursing Care (16-24).
  - b. Medical Social Worker (1-2) if clinical/social indications for aid in adjustment to the severity and limitations of the medical condition; and in burn cases, social planning as for school or job.
  - c. Physical Therapist (8-16).
  - d. Occupational Therapist (2-8).
  - e. Home Health Aide (16-24).

**3. Goals**

- a. Promote wound or burn or decubiti healing and prevent complications, e.g., dressings, observe for infection.
- b. Orientation and supervision of patient and relatives/associates in self-care regarding the wound or burn or decubiti care.
- c. Orientation of patient and relatives/associates in prevention of decubiti.

**4. Monthly Case Evaluation (1-2)**

**CRITERIA CHAPTER 10.1**  
**CRITERIA FOR AUTHORIZATION OF DRUGS AND MEDICAL SUPPLIES**

Authorization is not required for payment of a drug or medical supply when the item is:

1. Listed in the Medi-Cal Drug Formulary or Medical Supply Sections 59999 or 59998, specifically matches the applicable description, and is provided in accordance with condition(s) set forth therein; or is
2. Administered to a patient as a part of a physician's, dentist's, or podiatrist's service and is billed to the program in conjunction with that service; or is
3. Provided under the "Emergency Services" provisions of Section 51056; or is
4. Provided to acute hospital care patients at the time of discharge, in quantities not exceeding a ten days' supply and the charges for the item are incorporated in the hospital's claim for the beneficiary's inpatient services.

Authorization is required for a drug or medical supply when the item:

1. Is not listed in the Formulary under Sections 59999 or 59998; or
2. Is listed but it does not clearly match the applicable Formulary description, or is intended to be provided to a beneficiary under conditions other than specified therein, or is requested (as applicable) for a beneficiary who has been placed on partial or fully restricted drug benefits status; or
3. Has a higher cost than the Federal Allowable Cost or Maximum Allowable Ingredient Cost and full reimbursement is desired by the provider.

Authorization cannot be granted for any item specifically excluded from program coverage.

*Authorization Guidelines*

- I. Basis of Approval
- II. Clinical and Drug Information From the Provider
- III. Processing Standards
- IV. Types of Items Which May Be Authorized and Applicable Guidelines
- V. Items Excluded From Coverage
- I. General Basis for Approval of Treatment Authorization Requests (TARs)
  - A. Approval of a request may be granted when the information submitted by the provider is complete and a determination is made that:
    1. The item is medically necessary and there is no suitable alternative listed on the Formulary and no lower cost non-Formulary choice, and it is clinically compatible with the patient's medical condition as well as other drugs or medical supplies being used by the patient, or

2. The clinical condition of the patient requires override of a Formulary specified coverage restriction, Maximum Allowable Ingredient Cost/Federal Allowable Cost (MAIC/FAC) price level, or
3. Approval of the request will result in less costly treatment than would otherwise occur.

## II. Clinical and Drug Information From the Provider

### A. Diagnosis.

A diagnosis and related clinical information which support the request must be submitted by the provider.

### B. Strength and quantity of the item requested.

The strength and quantity of the item requested must be specified, and the number of refills, if any.

### C. Directions for use.

Specific directions for use must be given. For example, "Take as directed" or "Take one as necessary" are ambiguous and not acceptable.

### D. Brands.

On request for approval of a multiple source item, the brand to be dispensed must be specified.

## III. Processing Standards

- A. Clinical information submitted with the request must be comprehensive enough to make a determination that approval of the request is medically and/or cost justified.
- B. When appropriate, an explanation should be included indicating what alternatives not requiring authorization have been considered or tried and why they were not usable.
- C. Laboratory data (biochemical, radiological, culture/sensitivity, etc.), to support a request will be required when appropriate.
- D. The provider should offer an explanation of the anticipated duration of need of the item, and:
  1. The quantity requested should be granted if it is in accordance with the beneficiary's clinical need and the chronicity of the condition. The authorized quantity will be adjusted when the requested quantity is not appropriate.
  2. Up to (but not more than) a 100 calendar day supply may be authorized for each prescription dispensed.

3. Refills may be granted for up to a maximum of one year when the use of the item, as authorized, is clearly expected to continue unmodified for up to or beyond one year.
- E. Only the lowest cost brand of any multiple source item carried in the pharmacy provider's stock that meets the clinical need of the beneficiary may be authorized. The brand approved must be specified on the TAR. When an MAIC or FAC is applicable, a higher cost brand may only be approved as provided below under IV.B.1.
- F. Any item designated either preliminary or final "Ineffective" or "Safety" issue rating by the Food and Drug Administration (FDA), should only be authorized when the prescriber provides the consultant verbal or written assurance that there is no suitable alternative rated safe and effective, on or off the Formulary, which will meet the patient's need.  
  
Similar cautious attention should be given to approval of any item rated "Possibly" or "Probably" effective/safe for the intended clinical use of the patient for whom requested.
- G. Authorization is required for use of a listed dosage form of a drug by a *different* route of administration and may be granted as provided below under IV.C.3 and 4.
- H. Authorization is required for a listed drug when prepared by the provider in an unlisted (FDA approved) dosage form or dosage strength for use by the *same* route of administration. The provider's claim is payable without a TAR by use of the appropriate four-digit numerical code plus the letter Z (e.g., 0000Z).
- I. Authorization cannot be granted for override of bulk package or direct price Estimated Acquisition Cost (EAC) reimbursement limits specified under Sections 51513 (a) (10) and 51513.5.

#### IV. Items Which May Be Authorized and Applicable Guidelines

- A. Drugs and medical supplies not listed in Section 59999 or 59998 and not excluded from coverage.
- B. Prescriptions which do not meet specific price and dispensing limitations applicable to certain Formulary drugs and medical supplies. These include:
  1. A product of higher cost than the FAC or MAIC limit, in accordance with the procedural requirements set forth in Section 51513 (a) (14).
  2. Prescription quantities less than:
    - a. One hundred tablets/capsules of designated drugs specified under the provisions of Section 51513 (b) (2).
    - b. Three cycle quantities of oral contraceptives specified under the provisions of Section 51513 (b) (4).
    - c. 480 cc quantities of Theophylline and Potassium supplement liquids specified under the provisions of Section 51513 (b) (5).

3. Fourth and subsequent prescriptions in any 75-day period for designated drugs subject to the 3 prescriptions in 75 days limitation specified under the provisions of Section 51513 (b) (3).
  4. Prescription quantities more than the maximums specified in the Formulary for codeine combination drugs and hypnotic drugs.
- C. Exceptions to Formulary condition(s) of use. For example, approval of payment for:
1. Influenza vaccine for immunization of home or community care patients (except when administered by a physician in which case the charge for the vaccine is billed by the physician).
  2. Baclofen for FDA approved treatment of conditions other than spasticity resulting from multiple sclerosis or spinal cord injury as specified under the Formulary entry.
  3. Use of a listed dosage form of a drug for a *different* (FDA approved) route of administration.
  4. Preparation by the provider of an unlisted dosage form of a listed drug, for use by a *different* (FDA approved) route of administration.
- D. Liquid Sorbitol when used for the prevention or treatment of constipation due to the administration of Sodium Polystyrene Sulfonate to patients (except skilled nursing facilities/intermediate care facilities [SNFs/ICFs] patients) with end-stage renal disease.
- E. Localized ganglionic stimulating laxative suppositories for patients (except SNF/ICF inpatients) medically diagnosed with paraplegia or quadriplegia; multiple sclerosis; poliomyelitis; ganglionic blockade processes occurring in the spinal nerve pathways or affecting the lumbrosacral autonomic nervous system pathways related to bowel motility, when the disease affects bowel motility.
- F. Formulary items for a beneficiary whose drug program benefits have been placed on restriction because the beneficiary has been found to be abusing those benefits.
- G. Unlabeled uses.

Unlabeled use of drugs or medical supplies means the use of an already marketed item for a clinical indication not listed in the approved labeling of the item by the federal Food and Drug Administration (See Title XXII, Section 51056.2).

Prior authorization for unlabeled use of items may be given when the requested unlabeled use represents reasonable and current prescribing practice. The determination of reasonable and current prescribing practice should be based on reference to current medical literature and consultation with provider organizations, academic and professional specialists [see Title XXII, Section 51313 (c) (4)]. For this purpose, sources of input may include but not be limited to professional organizations such as the American Medical Association (AMA), California Medical Association (CMA), medical/surgical specialty organizations, and reference to current medical literature such as a AMA Drug Evaluations, Current Therapy, Drugs of Choice, The Pharmacological Basis of Therapeutics, Harrison's Principles of Internal Medicine, Textbook of Medicine, the Medical Letter, Rational Drug Therapy, J.A.M.A., Clinical Pharmacology and Therapeutics.

The procedure for handling requests for authorization of commercially available items prescribed for unlabeled uses are as follows:

1. The request is referred to the Field Services Supervising Pharmacist or his designee.
2. The Field Services Supervising Pharmacist, if necessary, in consultation with Benefits Branch Consulting Pharmacists, will review the request and make the TAR determination.

Prior to referring those TARs, the consultant receiving the request should obtain from the provider reasonable documentation or references to support the intended use of the item is accepted as safe and effective for general use by the medical community. However, when an unlabeled use of an item has been previously documented by the field office as safe and effective for general use, additional data from providers should not be required unless deemed justifiably necessary because of the nature of the particular request.

- H. Nutritional supplements or replacements may be authorized except for patients in SNF/ICF if used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular foodstuffs.

#### V. Items Excluded From Coverage

- A. Supplies not primarily medical in nature such as toothbrushes, toothpaste, denture cleaner, shaving soaps and lotions, cigarettes, cigars, pipes and tobacco, cosmetics, hair combs and brushes, tissue wipes.
- B. Common household remedies which are frequently and usually purchased for self use by the public in general for self treatment of bodily diseases or ailments generally not requiring diagnosis and treatment by a licensed practitioner.
- C. Benzoic and Salicylic acid ointment (precompounded), Salicylic acid cream or ointment, Salicylic acid liquid, Sodium Chloride tablets 1 gm and 2.5 gm, Zinc Oxide paste, nonlegend analgesics except those listed in Section 59999 (c) of the Formulary.
- D. Laxatives and agents affecting fecal consistency, except by prior authorization in certain clinical situations as specified above under IV. D and E.
- E. Nutritional supplements or replacements, except by prior authorization in certain clinical situations as specified above under IV. H.
- F. Vitamin combinations for persons after their fifth birthday.
- G. Any drug or medical supply used experimentally [see Title 22, Sections 51056.1 (a) (c) and 51303 (g)] or used investigationaly [see Title XXII, Section 51056.1 (b) (c) and Section 51303 (h) for exceptions.]



- H. Certain items for SNF/ICF inpatients, which are commonly used in providing skilled nursing care and, therefore, must be furnished by the facility under the provisions of Sections 51510 and 51511. These items include nonlegend analgesics [in addition to those listed in Section 59999 (c) of the Formulary], laxatives (including stool softeners), lubricants, rubbing compounds, antiseptics, \* first aid supplies, \*\* hypodermic syringes (and needles), nutritional supplements and replacements, Sodium Chloride irrigating solution, rubber goods such as rectal tubes, catheters, gavage tubing, soft restraints, incontinence pads, urine bags, colostomy or ileostomy pouches and accessories, gauze dressing, thermometers, tongue depressors, applicators, bedside utensils (such as bedpans, basins, irrigating cans, and drinking tubes), and any other supplies commonly used in providing SNF/ICF care.

Also excluded are those items listed in Section 59998 which are not preceded by a double asterisk (\*\*) or any other item which is not required and prescribed for a specific inpatient for his or her exclusive use.

- I. Any item not prescribed by a licensed physician, dentist, or podiatrist.
- J. Quantities exceeding a 100 calendar day supply.
- K. Incontinence supplies for persons up to the fifth birthday.
- L. Sanitary napkins and tampons for normal hygiene associated with menstruation.
- M. Cotton, adhesive tapes, and elastic bandages.

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\* Antiseptic means any preparation containing an antimicrobial substance (except those listed in Drug Formulary and Medical Supply, Sections 59999 and 59998, and not specifically excluded from SNF/ICF coverage) to be used for local, oral, or topical application to broken or unbroken tissue as a cleanser or protectant to reduce the number of bacteria or minimize the potential for infection. However, when such preparation is uniquely prescribed for a specific patient as the primary modality of treatment of a serious infection for which it is labeled safe and effective, it may be authorized when neither it nor a suitable alternative is available from the facilities' floor stock. Antiseptic preparations or substances include, but are not limited to: alcohols (e.g., isopropyl or ethyl alcohol); acids (e.g., acetic acid, boric acid); surface active agents (e.g., quaternary ammonium compounds such as benzalkonium chloride, cetyl pyridinium chloride); phenols (e.g., hexachlorophene); halogenated compounds (e.g., iodine, iodophors, sodium hypochlorite); heavy metals (e.g., mercurials); oxidizing agents (e.g., peroxides); or other preparations containing substances similar in chemical structure or clinical uses.

\*\* First aid supplies mean any article or remedy commonly used for the immediate or minor treatment of cuts, burns, fractures, bleeding, poisoning, or other conditions in cases of accident or sudden illness. In addition to items listed in Sections 51510 and 51511, and other items intended for the same purpose, first aid supplies include: absorbent cotton, cotton balls and buds, sterile rolls and pads of gauze, muslin and elastic bandages, disposable fabric tissues and underpads, eye pads, sponges, tissues and towels, plaster of paris, adhesive plaster, adhesive elastic bandages, aerosol adherent, spray dressings, first aid kits, sterile gauze compresses, adhesive tape, elastic roll bandages, arm sling, adhesive strip bandages, needle for splinter removal, cotton tipped swabs, burn ointment, tourniquet, rubbing compounds, ammonia inhalant ampules, salt tablets, antiseptic soap, effervescent antacid/analgesic, epsom salts, dry mustard, bicarbonate of soda, universal antidote for poisons, hot water bottles, safety pins, eye cups, leg and arm splints. Note, some first aid items may be identical, related, or similar to those listed in Sections 59999 and 59998 that are specifically excluded from SNF/ICF coverage. Some may also be classified as common household articles or remedies.

## **CRITERIA MANUAL CHAPTER 11 CRITERIA FOR HOSPICE CARE**

### **I. Medi-Cal Regulations**

**Title 22, California Code of Regulations (CCR), Sections 51003, 51180, 51180.1, 51180.2, 51180.3, 51180.4, 51180.5, 51180.6, 51180.7, 51250, 51349, and 51544.**

### **II. General**

- A. Hospice care is covered subject to the requirements specified in the above regulations. Providers must be Medicare certified and all services must be provided in conformance with Medicare requirements.**
- B. Persons entitled to Medicare Part A services shall be approved for hospice benefits under Medi-Cal at such time and for the same periods as Medicare benefits are elected. Medicare will be the first payor with Medi-Cal covering any applicable room and board payments specified in Title 22, CCR, Section 51544 (h) and any applicable coinsurance amounts specified in Title 22, CCR, Section 51544 (i).**
- C. In order to be eligible for hospice care an individual must be certified as terminally ill each period in which hospice care is elected. For the initial 90-day period, the certification must be made by the medical director or the physician member of the hospice, and by that individual's attending physician. For subsequent periods, the certification may be made by either the medical director, or the physician member of the hospice. An individual is considered terminally ill only if his or her life expectancy is six months or less.**
- D. A written plan of care which conforms to all Medicare requirements must be established by the hospice for each patient before services are rendered.**
- E. An election statement which conforms to all Medicare requirements must be filed by the beneficiary, or the beneficiary's representative, with the hospice and may be considered to continue through the initial election period and through the subsequent election periods without a break in care, if the individual remains in the care of a hospice and does not revoke the election. The election statement cannot be made retroactive.**
- F. Of the four care levels described in regulation: routine home, continuous home, respite, or general inpatient, Treatment Authorization Requests (TARs) shall be required only for general inpatient care. Routine home care, continuous home care and respite care do not require prior authorization.**
  - 1. Routine home care is defined as that care provided in the patient's home.**

2. Continuous home care consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours during brief crisis periods. Home health aide and/or homemaker services may also be provided.
  3. Respite care occurs when the patient receives care in an approved inpatient facility on a short-term basis to provide relief for family members or others caring for the patient. Each episode is limited to no more than five days.
  4. General inpatient care occurs when the patient receives general care in an inpatient facility for pain control, or acute/severe symptom management that cannot be managed in other settings.
- G. A TAR for general inpatient care for the first 90 days may be approved only upon receipt by the Medi-Cal consultant of a copy of the certification of the patient's terminal condition, a copy of the written initial plan of care, and a copy of the individual's signed election statement. A copy of the complete plan of care, signed by the hospice medical director, or the patient's attending physician must be received by the Medi-Cal consultant not later than two weeks from the day care is initiated.
- A TAR for general inpatient care for the subsequent 90-day, 30-day, or extension of the final 30-day period may be approved only upon receipt by the Medi-Cal consultant of a copy of a recertification of the patient's terminal condition, signed by either the medical director of the hospice, the physician member of the hospice's interdisciplinary group, or the individual's attending physician.
- H. Room and board payments for residents of Nursing Facility Level B (NF/B) and Nursing Facility Level A (NF/A) (code numbers 135 and 155) will not require line item approval on the TAR. However, room and board payments shall be made only on behalf of a beneficiary who has been determined eligible for NF/A or NF/B level of care and instead elects to receive hospice care.
- I. TARs for curative services related to the individual's terminal illness shall not be approved during any time the patient has elected any level of hospice care. Services related to the individual's terminal illness may only be provided by the hospice care provider or the attending physician. Services not related to the patient's terminal illness, e.g., preexisting diabetes, or an injury sustained in an accident, may be provided under the patient's general Medi-Cal coverage, subject to applicable Medi-Cal restrictions and controls.

If the hospice provider determines that the patient has revoked his/her election, necessary services may be provided in the usual manner subject to applicable Medi-Cal restrictions and controls.

### III. Providers

Providers of hospice service may include a hospital, a NF/B, a NF/A, a home health agency, or any other licensed health provider certified by Medicare to provide hospice care. Payments made to hospice providers shall be for one or more of the four levels of hospice care, for physician services not included in the hospice care rates, for coinsurance for drugs and respite care on behalf of dually eligible (Title XVIII/Title XIX) beneficiaries, and for room and board payments on behalf of persons who are residents of a NF/B or NF/A. Separate payment will not be made, or TARs approved, for hospital, NF/B, NF/A, or home health agency care while an individual is under the care of a hospice, nor will payment be made, or TARs approved, for medical supplies and appliances, drugs and biologicals, durable medical equipment or any other service, as specified in regulation, which is included in any of the four levels of hospice care.

### IV. Criteria for Authorization of General Inpatient Care

General inpatient care may be approved on a short-term basis for pain control or management of acute and severe problems which cannot be managed elsewhere and/or when death is imminent and the family is unable to cope at home.

Documentation of need for authorization of general inpatient care in one or more of the following areas is required:

- A. Pain control requiring:
  - 1. Frequent evaluation by a physician/registered nurse.
  - 2. More aggressive treatment to control pain than can be attained in a home setting.
  - 3. Frequent adjustment of medications.
- B. Management of symptoms such as:
  - 1. Sudden acute general deterioration requiring intensive nursing intervention.
  - 2. Protracted nausea and vomiting.

3. Respiratory distress which becomes unmanageable, requiring administration of continuous oxygen.
- C. Major pathological fracture.
  - D. Open lesions not responsive to home care and in need of frequent skilled care.
  - E. Rapid decline or debilitating cachexia inconsistent with home care management.
  - F. Psychological and social problems such as, but not limited to:
    1. Acute anxiety or depression not responding to milieu therapy.
    2. Collapse of family support resulting from the disease process, which requires intensive skilled care in other than the home environment.
    3. Psychosis or severe confusion secondary to the underlying organic disease.
- V. Documentation Requirements

In addition to the documents specified in II. G, TARs requesting authorization of general inpatient care shall include the following:

- A. A written prescription signed by the patient's attending physician.
- B. Documentation that general inpatient care is necessary, for one or more of the reasons specified in IV above.

**CRITERIA MANUAL CHAPTER 12.1****CRITERIA FOR MEDICAL TRANSPORTATION AND RELATED SERVICES****. I. Emergency Medical Transportation**

Emergency medical transportation is provided when necessary to obtain program covered benefits when the beneficiary's medical/physical condition is acute and severe, necessitating immediate medical diagnosis and treatment so as to prevent death or disability. [Title 22, CCR, Section 51056 (a)] Such transportation does not require prior authorization and is always by ambulance, with such vehicles satisfying the standards established by the California Highway Patrol.

Medical transportation which represents a continuation of an original emergency transportation event is also covered without prior authorization, such as transportation from an emergency room of one hospital on to a second hospital for admission or for emergency services when the initial emergency room cannot provide the appropriate emergency medical treatment.

***Ambulance***

Ambulance service may be indicated in cases where supportive medical devices or services are required in transit (e.g., suction, mechanical cardiac monitoring, continuous intravenous fluids, constant oxygen). In each of the following categories, some medical conditions are listed as examples, but all possible conditions are not noted.

Emergency ambulance transport may be required in cases of:

- A. Acute respiratory distress in which oxygen therapy, suction, and/or mechanical ventilation is required, such as in cases of:
  - 1. Acute, severe cyanotic pneumonia.
  - 2. Status asthmaticus.
- B. Acute coma or stupor states such as in cases of:
  - 1. Acute brain hemorrhage.
  - 2. Acute severe head trauma.
  - 3. Diabetic coma.
- C. Acute cardiac conditions in which mechanical cardiac monitoring is required during transport such as in cases of:
  - 1. Acute myocardial infarction.
  - 2. Acute heart failure with severe dyspnea and cyanosis.

- D. **Premature or severely ill newborns where a neonatal intensive care incubator or other medical supportive device is required during transport such as in cases of:**
  - 1. **Severe respiratory distress syndrome.**
  - 2. **Severe cyanotic congenital heart disease.**
  - 3. **Anoxic brain injury with irregular respirations and cyanosis.**
- E. **Acute, persistent shock states requiring medical supportive devices (i.v. fluids, oxygen) such as may occur in cases of:**
  - 1. **Severe blood loss.**
  - 2. **Severe trauma.**
  - 3. **Heat prostration.**
- F. **Acute trauma cases involving extensive injuries of the head, chest, abdomen, or back, with closed or open wounds, requiring supportive medical devices.**
- G. **Acute, severe hemorrhage, frequently with accompanying shock state, such as in cases of:**
  - 1. **Massive gastrointestinal hemorrhage.**
  - 2. **Severed major artery of the body.**
- H. **Acute burn cases of extensive area and degree (greater than five percent of body area and of second or third degree) in which supportive medical devices are required such as intravenous fluids, suction, protective tenting over the burn area.**
- I. **Medical conditions with severe and persistent vomiting requiring suction to avoid aspiration, and/or severe diarrhea with profound dehydration and collapse, such as in cases of:**
  - 1. **Acute gastrointestinal hemorrhage with frequent, persistent vomiting.**
  - 2. **Acute intestinal obstruction with frequent persistent vomiting.**
  - 3. **Acute severe infantile diarrhea states.**
- J. **Status epilepticus in cases of grand mal seizure occurring more frequently than every two hours with persistent confusion in which suction and oxygen are required during transport.**
- K. **Pregnancy cases in the active stage of delivery.**
- L. **Acute severe mental or emotional disturbance of such a degree as to require four point restraint.**

## II. Nonemergency Medical Transportation

Nonemergency medical transportation is provided when necessary to obtain program covered medical services and when the beneficiary's medical and physical condition is such that transport by ordinary means of private or public conveyance is medically contraindicated. This type of medical transportation is subject to prior authorization. Each authorization request for such transportation must be accompanied by either a prescription or order signed by a physician, dentist, or podiatrist, which describes the *medical* reasons necessitating the use of nonemergency medical transportation.

Authorization is granted only for the lowest cost type of medical transport that is adequate for the patient's medical needs and is available to transport the patient at the time transportation is required.

### A. *Ambulance*--must be authorized in cases of:

1. Medically necessary transfer of cases between acute inpatient facilities for care, or for special testing (e.g., CT scan), where the patient's medical/physical condition is definitely unstable and/or medical support devices are required, such as in cases of:
  - a. Newborn being transferred in an intensive care incubator from a neonatal intensive care unit to an intermediate care unit.
  - b. Comatose acute stroke patient being sent for brain CT scan and requires suction during transport.
2. Posthospitalization transportation of the patient to a long-term care facility or to home when the medical/physical condition requires recumbency and medical supportive devices (e.g., intravenous fluids, suction), such as in cases of:
 

Poststroke patient who is stuporous and has difficulty clearing secretions.
3. Chronic respiratory distress patient who requires continuous oxygen and cannot utilize self-portable oxygen and private or public transport due to other specific medical/physical conditions, such as in cases of:
  - a. Severe emphysema requiring constant oxygen in a patient with severe hemiplegia.
  - b. Severe emphysema requiring constant oxygen in a patient with deforming arthritis which prevents sitting upright, standing, or ambulating.
4. Chronic cardiac conditions in which machine monitoring is required during transport, such as in a case of:
  - a. Interhospital transfer of a patient with coronary artery disease or congestive heart failure for cardiovascular studies.
  - b. Bedfast patient with chronic cardiac arrhythmia and progressive dyspnea for cardiovascular evaluation and tests.



**B. *Litter Van (Gurney Car)*—may be indicated in cases of:**

1. Medically necessary transport of patients for special testing (e.g., CT scan), radiation therapy, or in transfer to a lower level of care, or to home, when the patient's medical/physical condition is stable, requires recumbency, and does not require medical supportive devices or observation, such as in a case of:
  - a. Suspected brain tumor case with severe lethargy and hemiparesis being sent for a brain CT scan.
  - b. Bedfast patient in a skilled nursing facility with a diagnosis of arteriosclerotic heart disease being sent for medical testing (e.g., CT scan).
2. Body cast case.
3. Hip spica cast case.
4. Cases where medical/physical condition(s) preclude sitting upright for any period of time, such as, but not necessarily limited to:
  - a. Multiple decubiti, requiring recumbent (prone or supine) position due to location of the lesions.
  - b. Severe orthostatic hypotension so that the patient always faints when upright, such as in a case of:
 

Shy-Drager's syndrome with severe orthostatic hypotension.
  - c. Traction apparatus in place precludes upright position.
  - d. Subacute extensive burn cases being transferred for dressing changes and location of the lesions requires a recumbent position.
  - e. Bedfast case who cannot ambulate or sit upright for the period of medical transportation due to medical/physical conditions, such as in case of:
    - (1) Severe paralysis of the legs with cachexia and fainting when upright.
    - (2) Severe debilitating cachexia as in metastatic cancer.
  - f. Cases with severe arthritic conditions of the back and/or lower extremities with definite severe limited range of motion precluding sitting or ambulating.
5. Posthospitalization cases being transferred to a long-term care facility, or home, where the medical/physical condition requires recumbency, but no supportive medical devices are necessary, such as, but not necessarily limited to:
 

Poststroke case with severe hemiplegia who faints on sitting or standing.

6. If litter van (gurney car) is not at all available from any source in the area, consideration may be given for ambulance transportation concerning cases as exemplified in categories B.1 through 6.

**C. *Wheelchair Van***—may be indicated in cases of:

1. Beneficiary is wheelchair bound, and unable to self-transfer to a private or public conveyance, or cannot reasonably ambulate even with assistance or use of a walker or crutches so as to use a private or public conveyance, such as, but not limited to cases of:
  - a. Bilateral amputee without prostheses.
  - b. Severe paraplegic without bracing.
  - c. General physical weakness and inability to ambulate without assistance due to old age.
2. Hemodialysis cases may be considered if there is sufficient documentation from the attending physician or by on-site visit that significant altered physical state pre or posttreatment medically contraindicates the use of private or public transportation.
3. Cases with definite mental confusion where transport requires qualified attendant supervision.
4. Inpatient cases who are wheelchair bound and require transport to another facility for medically necessary tests such as CT scan, or radiation therapy.

**III. Contraindications to the Use of Private or Public Transportation**

Contraindications to the use of private or public transportation (bicycle, car, taxi, bus) may involve, but are not necessarily limited to:

- A. Acute, severe, emergent medical conditions as listed in I.A.
- B. Medical/physical conditions of the beneficiary where the beneficiary is:
  1. Unable to ride upright in a private or public vehicle.
 

See II.B.4.
  2. Unable to transfer into a private or public vehicle such as, but not limited to cases of:
    - a. Paraplegia.
    - b. Severe dysfunction of upper and lower extremities, e.g., severe paraplegic without bracing who has deforming arthritis of the upper extremities.
    - c. Severe deforming disease of back or lower extremities, e.g., "stiff man syndrome—severe."

3. The medical condition precludes being able to reasonably ambulate to a vehicle or a bus stop or board a vehicle such as, but not limited to:
  - a. Lesions of the feet due to active disease.
  - b. Severe deforming disease of the back or lower extremities with definite limited range of motion.
  - c. Severe chronic asthenia due to disease, e.g., severe cachexia.
  - d. Wheelchair-bound cases due to chronic severe musculoskeletal and/or neurologic diseases; unable to stand or walk even with assistance.
  - e. Extreme weakness or history of recurring syncope.
4. The medical condition of the beneficiary, who has a special automobile, has progressed or changed so that the beneficiary cannot reasonably transfer into and/or drive the vehicle and/or use other private or public transport as in B. 1, 2, or 3.

**CRITERIA MANUAL CHAPTER 13.0**  
**CRITERIA FOR DURABLE MEDICAL EQUIPMENT**

## CRITERIA MANUAL CHAPTER (13.1)

### ANTIDECUBITUS CARE (ADC) SUPPORT SURFACES

- I. Antidecubitus Care (ADC) support surfaces, as defined in Section IV.F. below, are covered by the Medi-Cal program in accordance with the requirements of Title 22, California Code of Regulations (CCR), Sections 51321 and 51521.
- II. Prior Authorization is required:
  - A. For the purchase of listed ADC support surfaces, equipment, and supplies when the cumulative cost within the calendar month of purchasing items within the group exceeds \$100.
  - B. For the repair or maintenance of ADC support surfaces, equipment, and supplies when the cumulative cost within the calendar month within the group exceeds \$250.
  - C. For the rental of ADC support surfaces, equipment, and supplies when the cumulative cost within the group exceeds \$50.00 within a fifteen month period.
  - D. For all unlisted ADC support surfaces, equipment, and supplies.

Authorization for ADC support surfaces, equipment, and supplies shall be based upon medical necessity substantiated by documentation submitted with the Treatment Authorization Request (TAR). Authorization may be granted in increments of up to 30 days, as medically necessary.

- III. The lowest cost ADC support surface shall be approved unless one of the following conditions exist:
  - A. Documentation submitted with the TAR indicates that the lowest cost support surface has been tried and has failed to meet the patient's support surface needs.
  - B. Documentation submitted with the TAR demonstrates that the lowest cost support surface is clearly inappropriate for the specific patient.
- IV. For the purposes of adjudicating TARs for ADC support surfaces, the following shall apply:
  - A. "Trunk of the body" means the bottom of the neck down to and including the groin/buttocks area, excluding the limbs.
  - B. "Turning Surfaces" means the surfaces of the body onto which the patient may be turned. Patients are presumed to have four turning surfaces on which to lie, i.e. prone, supine, right side and left side, unless documented otherwise. Conditions other than pressure sore(s) may preclude the patient from lying on one or more of the otherwise available turning surfaces. The way in which any

condition(s) limit(s) a turning surface shall be specifically detailed along with the request for prior authorization.

- C. The terms "decubitus ulcer," "pressure sore," and "wound" may be used interchangeably.
- D. Stages of decubitus ulcers:
1. "Stage I Decubitus Ulcer" means a nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
  2. "Stage II Decubitus Ulcer" means partial thickness loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.
  3. "Stage III Decubitus Ulcer" means full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
  4. "Stage IV Decubitus Ulcer" means full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Undermining and sinus tracts may also be associated with this stage.
- E. Support Surface Categories:
1. "Pressure reducing surfaces" means a static or dynamic surface which reduces pressure from the level found with a standard mattress or wheelchair cushion, but does not consistently maintain interface pressures below normal capillary closing pressures.
    - a. "Static surfaces" means those surfaces designed to provide support that remains constant, i.e., does not cycle in time.
    - b. "Dynamic surfaces" means those surfaces designed to change their support characteristics in a cyclic fashion
  2. "Pressure relieving surfaces" means those surfaces which consistently maintain interface pressures below normal capillary closing pressures. Pressure relieving devices are always dynamic.
- F. Support Surface Product Definitions:
1. "Alternating Air Pressure or Overlay" means a mattress or overlay with interconnecting air cells that cyclically inflate and deflate to produce alternating high and low pressure intervals. Cells with larger depth and diameter produce greater pressure relief over the body.

2. "Mattress Replacement System" means a mattress with pressure-reducing or pressure relieving features that can be placed on an existing bed frame. The mattress shall be at least 8 inches thick.
3. "Overlay" means support surfaces placed on top of a standard hospital mattress.
4. "Air Fluidized Bed" means a class of support surface that uses a high rate of air flow to fluidize fine particulate material (such as sand) to produce a support medium that has characteristics similar to a liquid.
5. "Low Air Loss Bed" means a series of interconnected woven fabric air pillows that allow some air to escape through the support surface. The pillows can be variably inflated to adjust the level of pressure relief.

V. ADC support surfaces are categorized below as Group I or Group II products:

- A. "Group I products" means static overlays, static mattresses and alternating pressure pads with pump. With the exception of the alternating pressure pad with pump, Group I products are not separately payable outside the nursing facility daily rate of reimbursement when the place of service is a long-term care facility.

Authorization of a Group I product may be granted by a Medi-Cal consultant, if the documentation submitted with the TAR supports the medical necessity of the requested product and indicates that the patient has at least one of the conditions specified below:

1. Current stage I or stage II pressure sore(s) on the trunk of the body.
2. History of stage III or stage IV pressure sore(s) on the trunk of the body.
3. Patient is bed bound and requires the support surface for pressure sore prevention.

- B. "Group II products" means dynamic overlays (except alternating pressure pad with pump), dynamic mattress replacement systems, and specialty full-frame beds. Authorization of a Group II product may be granted by a Medi-Cal consultant, if the documentation submitted with the TAR supports the medical necessity of the requested product and indicates that the patient has one of the conditions specified below:

- 1 For dynamic overlays:
  - a. The patient has at least one large stage III or stage IV pressure sore (greater than 2 x 2 cm) on the trunk of the body, with only two turning surfaces on which to lie.
  - b. The patient has multiple (more than two) stage III or stage IV pressure sores, with at least three turning surfaces on which to lie.

2. For dynamic mattress replacement systems:
  - a. The patient has at least one large stage III or stage IV pressure sore (greater than 3 x 3 cm.) on the trunk of the body, and at least one other wound on the trunk of the body, with only two turning surfaces on which to lie.
  - b. The patient has multiple (more than two) stage III or stage IV pressure sores, with only two turning surfaces on which to lie.
3. For specialty full-frame beds--Low Air Loss Therapy or Air Fluidized Therapy.
  - a. The patient has at least one stage III or stage IV pressure sore on the trunk of the body with only one or no turning surfaces upon which to lie.
  - b. The patient is within two weeks post flap surgery.

#### VI. Documentation Requirements.

- A. Documentation submitted with TARs for Group I products, regardless of place of service, shall include all of the following:
  1. A written prescription signed by the prescribing practitioner.
  2. Number of wounds.
  3. The stage and size of each wound, including undermining.
  4. Description of each wound, including amount and color of exudate.
  5. Location of each wound.
  6. Relevant wound history, including any prior pressure sore(s).
  7. Relevant history of patient's use of pressure sore equipment.
- B. In addition to the documentation specified in A.1 through 7 above, documentation submitted with TARs for Group II products, regardless of place of service, shall include all of the following:
  1. The number of turning surfaces affected, including why other comorbidities may preclude the patient from lying on one or more turning surfaces.
  2. Nutritional status, including a nutritional assessment completed by a registered dietician, in consultation with the primary physician or nurse practitioner, that includes the patient history, a physical examination, and



laboratory data. If the assessment indicates the presence of a nutritional deficit that may impair wound healing, there shall be a documented treatment plan that has been developed and implemented to improve the patient's nutritional status.

3. Nursing care, including turning, positioning, medication administration, and current treatments. The date of the initial patient assessment, comorbidities and sensorium shall also be included. There must be documentation that appropriate nursing care is occurring.
4. Wound care, e.g., irrigation, packing, dressing, etc. There must be documentation that appropriate wound care is occurring.
5. Surgery (e.g., suitability for, time since operative intervention, etc.).
6. Laboratory results, performed within 7-10 days prior to placing the patient on the support surface, including the following:
  - a. Hemoglobin and Hematocrit
  - b. Serum Transferrin or Serum Albumin
  - c. Total Iron Binding Capacity (TIBC), as indicated by the patient's medical condition, or when requested by the Medi-Cal consultant
  - d. Urinalysis, as indicated by the patient's medical condition, or when requested by the Medi-Cal consultant

**Note:** Laboratory tests should rule out underlying anemia, protein deficiency, and urinary tract infection. While laboratory values alone will not preclude the authorization of support surfaces, if any laboratory results are abnormal, the provider shall submit a physician treatment plan to correct the problem which resulted in abnormal laboratory result(s) with the TAR.

#### VII. Reauthorization TARs:

- A. Documentation submitted with reauthorization TARs shall include all of the following:
  1. Updated treatment and care plans, as indicated.
  2. Reevaluation of the healing status of the pressure sore(s), including updating of size, number and location of wounds and turning surfaces affected.
  3. Repeat laboratory studies, if previous ones were abnormal.
  4. Documentation of patient compliance with the treatment plan and the patient's use of the authorized surface.

- B. For patients with chronic wounds:**
- 1. For purposes of TAR adjudication, chronic wound patients are defined as those patients who have used the same level of support surface for four months or longer.**
  - 2. In addition to the documentation requirements listed in A. 1 through 4 above, additional documentation shall be submitted with a reauthorization TAR for the chronic wound patient including both of the following:**
    - a. The updated care plan shall address any significant problems with wound healing.**
    - b. Physician evaluation of possible alternative medical treatment to improve wound healing.**
  - 3. The support surface request for the chronic wound patient shall be considered for step down to a lower cost product in the following situations:**
    - a. If the documentation requirements in A. 1 through 4 and B.2.a. and b. are not submitted or cannot be provided.**
    - b. If the patient has refused to utilize the authorized surface or has refused to comply with other needed aspects of the treatment plan.**
    - c. If the patient has been on the same level of support surface for six or more months without documented improvement in wound status.**

**NOTE:** Providers of ADC support surfaces may utilize any flow sheets, decision trees or other tools that may be developed by the Medi-Cal program to assist in determining the most appropriate product to meet the patient's medical needs consistent with the foregoing criteria.

## CRITERIA MANUAL CHAPTER 13.2

OSTEOGENESIS STIMULATOR DEVICES TO ACCELERATE  
THE HEALING OF SELECTED BONE FRACTURES

- I. Non-invasive electrical bone growth stimulators and non-invasive low intensity ultrasound devices that have been approved for use by the Food and Drug Administration (FDA) and that are medically necessary to accelerate healing of selected bone fractures are covered by the Medi-Cal program as durable medical equipment in accordance with Title 22, California Code of Regulations (CCR), Section 51321.
- II. All such devices require prior authorization by a Medi-Cal consultant. Authorization shall be based upon medical necessity substantiated by documentation submitted with the Treatment Authorization Request (TAR).
- III. For the purposes of TAR adjudication, the following definitions shall apply:
  - A. "Closed fracture" means a fracture in which the broken bone is not accompanied by an external wound.
  - B. "Electrical bone growth stimulator" means a noninvasive device applied to the fracture site that uses electrical stimulation to accelerate healing of a nonunion fracture.
  - C. "Low intensity ultrasound device " means a noninvasive device that uses low intensity pulsed ultrasound applied to the skin surface overlying the break of a long bone to accelerate the healing of a fresh fracture.
  - D. "Nonunion fracture" means a fracture in which failure of the bone to heal (nonunion) is radiographically and clinically documented.
  - E. "Open fracture" means a fracture in which there is an external wound caused by the broken bone.
  - F. "Open tibial fracture" means a fracture that is classified as either Grade I, II, or III.
    1. A "Grade I open tibial fracture" means a fracture in which the wound is less than 1 centimeter with minimal soft tissue injury, the wound bed is clean, and the bone injury is simple with minimal comminution.
    2. A "Grade II open tibial fracture" means a fracture in which the wound is greater than 1 centimeter with moderate soft tissue injury, the wound bed is moderately contaminated, and the fracture contains moderate comminution.
    3. A "Grade III open tibial fracture" means a fracture in which the wound is greater than 10 centimeters with crushed tissue, the wound bed is highly contaminated, and the fracture contains severe comminution.

**IV. Electrical Bone Growth Stimulator**

- A. Authorization of electrical bone growth stimulators may be granted only when documentation substantiates both of the following:**
  - 1. The device shall be used to accelerate healing in nonunion of a long-bone fracture and/or fracture of the navicular bone of the wrist.**
  - 2. There shall be a radiographically and clinically established nonunion documented.**
- B. Electrical bone growth stimulation shall be provided in conjunction with conventional treatment, such as closed reduction, splinting or casting.**
- C. Documentation requirements for the authorization of an electrical bone growth stimulator shall include all of the following:**
  - 1. Written prescription signed by a physician.**
  - 2. Attending physician notes that indicate original date of injury, date conventional treatment began, specific medical and surgical treatment provided to date and results of such treatment.**
  - 3. Recent x-ray or imaging report prior to onset of electrical bone growth stimulation that documents nonunion.**
- D. Invasive bone stimulation or percutaneous bone stimulation, and electrical bone growth stimulation for fractures of any other bones, e.g., hip, rib cage, foot, hand; and bone growth stimulation in the immediate post-operative period have not been approved by the FDA and are not reimbursable under the Medi-Cal program.**

**V. Low-intensity Ultrasound Devices.**

- A. Low-intensity ultrasound devices may be authorized only for skeletally mature patients with the following clinical conditions:**
  - 1. A radiographically established fresh, e.g., within seven days of injury, closed fracture of the distal radius (Colles' fracture).**
  - 2. A fresh, e.g., within seven days of injury, closed, or grade I open tibial diaphysis fracture.**
- B. Low-intensity ultrasound shall be provided in conjunction with conventional treatment of closed reduction and cast management.**
- C. Documentation requirements for the authorization of ultrasound treatment of selected long-bone fractures shall include all of the following:**
  - 1. Written prescription signed by a physician.**

2. **Attending physician's clinical summary including date and type of injury and conventional treatment received.**
  3. **Recent x-ray or imaging report that documents the specific type of fracture.**
- D. **Low-intensity ultrasound treatment has not been determined by the FDA to be safe/effective in the following clinical situations and shall not be authorized for:**
1. **Other fracture locations.**
  2. **Fractures with post reduction displacement greater than 50 percent.**
  3. **Fractures that are open grade II or III; or that require surgical intervention; or with internal or external fixation; or that are not sufficiently stable for closed reduction and cast immobilization.**
  4. **Pregnant or nursing women.**
  5. **Patients with thrombophlebitis.**
  6. **Patients with vascular insufficiency.**
  7. **Patients with abnormal skin sensitivity or sensory paralysis.**
  8. **Patients with alcoholism and/or nutritional deficiency.**
  9. **Patients receiving therapies that affect bone metabolism, e.g., steroid, anticoagulant, prescription nonsteroidal anti-inflammatory, calcium channel blocker and/or diphosphonate therapy.**
- E. **Low-intensity ultrasound treatment for nonunion of established fractures is not reimbursable under the Medi-Cal program.**