

s 51030. Hearing Officer's Authority.

(a) The hearing officer may, on his/her own motion or the motion of any party, as the hearing officer deems appropriate:

(1) Consolidate for hearing or decision any number of issues or appeals when the facts and circumstances are similar and no substantial right of any party will be prejudiced.

(2) Join other parties, grant continuances and hold additional formal hearings as necessary to dispose of all issues.

(3) Hear any issue before any other issue in the proceeding where it is found that the decision on that issue could abate further proceedings.

(4) Prepare a proposed decision on any separately heard issue for the Director's signature and postpone hearing on any remaining issues until a final decision has been issued by the Director.

s 51031. Severance of Issues.

s 51032. Discovery.

(a) After the acceptance of the Statement of Disputed Issues, a party, upon written request made to another party, prior to the hearing and within thirty (30) calendar days after receipt of the Notice of Acceptance of the Statement of Disputed Issues or within fifteen (15) calendar days after the receipt of the Notice of Acceptance of an amended Statement of Disputed Issues or issuance of a Report of Findings, is entitled to:

(1) Obtain the names and addresses of witnesses to the extent known to the other party, including, but not limited to, those intended to be called to testify at the informal hearing or formal hearing.

(2) Inspect and make a copy of any of the following in the possession or custody or under the control of the other party:

(A) Statements pertaining to the subject matter of the proceeding made by any party to another party or person.

(B) Statements of witnesses then proposed to be called by the party and of other persons having personal knowledge of the acts, omissions or events which are the basis for disputed audit or examination findings, not included in subdivision (2)(A).

(C) All writings, including but not limited to audit work papers, patient ledgers, medical records and invoices or things which the party then proposes to offer into evidence.

(D) Other writing or thing which is relevant and which would be admissible in evidence.

(E) Investigative reports made for or on behalf of the Department or other party pertaining to the subject matter of the proceeding, to the extent that such reports:

(1) Contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the disputed audit or examination findings.

(2) Reflect matters perceived by the investigator in the course of his investigation.

(3) Contain or include by attachment any statement or writing described in subsections (2)(A) through (2)(D) inclusive, or summary thereof.

(4) For the purpose of this section, "statements" includes written statements by the person, signed or otherwise authenticated by the person, stenographic, mechanical, electrical or other recordings, or transcripts thereof, or oral statements by the person and written reports or summaries of such oral statements.

(5) Nothing in this section shall authorize the inspection or copying of any writing or thing which is privileged from disclosure by law or otherwise made confidential or protected as the attorney's work product.

(6) Any denial of discovery by a party shall be in writing and shall be accompanied by a written statement describing the specific reasons for denial as to each item of discovery denied. Such a denial shall be mailed within 30 calendar days from the date of filing the request for discovery.

(b) A party shall have the same rights as are accorded a party under the provisions of Section 11507.7 of the Government Code in the event that a request for discovery pursuant to this section has not been granted. In the event an order to show cause is issued, a copy shall be filed with each party.

(c) The provisions of this article provide the exclusive right to and method of discovery as to any proceeding governed by this article.

s 51033. Subpoenas and Witnesses.

(a) The hearing officer shall issue subpoenas and subpoenas duces tecum before the formal hearing, for attendance or production of documents at the formal hearing, as necessary or at the request of any party. The hearing officer may also issue subpoenas and subpoenas duces tecum after the formal hearing has commenced. Compliance with the provisions of Section 1985, California Code of Civil Procedure, shall be a condition precedent to the issuance of a subpoena duces tecum.

(b) The process issued pursuant to subsection (a) shall be extended to all parts of the State and shall be served in accordance with the provisions of Sections 1987 and 1988, California Code of Civil Procedure. No witness shall be obliged to attend at a place out of the county in which he resides unless the distance be less than 150 miles from his place of residence except that the hearing officer, upon affidavit of any party showing that the testimony of such witness is material and necessary, may endorse on the subpoena an order requiring the attendance of such witness.

(c) All witnesses appearing pursuant to subpoena, other than the parties or officers or employees of the State or any political subdivision thereof, shall receive fees and all witnesses appearing pursuant to subpoena, except the parties, shall receive mileage in the same amount and under the same circumstances as prescribed by law for witnesses in civil actions in a superior court.

(d) Witnesses appearing pursuant to subpoena, except the parties, who attend formal hearings at points so far removed from their residences as to prohibit return thereto from day to day shall be entitled, in addition to fees and mileage, to a per diem compensation of \$3.00 for expenses of subsistence for each day of actual attendance and for each day

necessarily occupied in traveling to and from the hearing. Fees, mileage and expenses of subsistence shall be paid by the party at whose request the witness is subpoenaed.

s 51034. Depositions.

(a) On verified petition of any party, the hearing officer may order that the testimony of any material witness residing within or without the State be taken by deposition in the manner prescribed by law for depositions in civil actions. The petition shall set forth:

- (1) The nature of the pending proceeding.
- (2) The name and address of the witness whose testimony is desired.
- (3) A showing of the materiality of his testimony.
- (4) A showing that the witness will be unable or cannot be compelled to attend.
- (5) A request for an order requiring the witness to appear and testify before an officer named in the petition for that purpose.

(b) The hearing officer's order for taking of testimony by deposition from a witness residing out-of-State shall be supported by a court order. The court order shall be obtained by filing a petition in the Superior Court of Sacramento County, in accordance with Section 11189, Government Code.

s 51035. Affidavits.

(a) Any party may mail or deliver to the opposing party, at least ten calendar days prior to a formal hearing or a continued hearing, a copy of any affidavit to be introduced in evidence, together with a notice as provided in subsection (b). Unless the opposing party, within seven days after such mailing or delivery, mails or delivers to the proponent a request to cross-examine an affiant, the right to cross-examine such affiant is waived and the affidavit, if introduced in evidence, shall be given the same effect as if the affiant had testified orally. If an opportunity to cross-examine an affiant is not offered after request

therefor is made as herein provided, the affidavit may be introduced in evidence, but shall be given only the same effect as other hearsay evidence.

(b) The notice referred to in subsection (a) shall be substantially in the following form:

NOTICE

The accompanying affidavit of (here insert name of affiant) will be introduced as evidence at the formal hearing in (here insert title of proceeding). (Here insert name of affiant) will not be called to testify orally and you will not be entitled to question him unless you notify (here insert name of proponent or his attorney) at (here insert address) that you wish to cross-examine him. To be effective your request must be mailed or delivered to (here insert name of proponent or his attorney) on or before (here insert a date seven days after the day of mailing or delivering the affidavit to the opposing party).

s 51036. Preparation for Formal Hearing.

A party appearing at a formal hearing shall have necessary evidence and witnesses present and be ready to proceed. Each party shall make available sufficient copies, as indicated by the hearing officer, of any documents to be introduced in evidence. The hearing officer, if necessary and following reasonable notice, may require any or all parties to submit a written statement of contentions and reasons, together with any requested documents. Each party submitting written statements and documents shall also provide a copy to all other parties.

s 51037. Conduct of Formal Hearing.

(a) Testimony shall be taken only on oath, affirmation or penalty of perjury.

(b) The proceedings at the formal hearing shall be electronically recorded.

(c) Each party shall have the right to:

(1) Call and examine parties and witnesses.

(2) Introduce exhibits.

(3) Question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination.

(4) Impeach any witness regardless of which party first called the witness to testify.

(5) Rebut the evidence against him.

(d) The provider shall not be called to testify during presentation of the Department's prima facie case pursuant to subsection (i). A provider who thereafter fails to testify, in the provider's behalf, may be called and examined by the Department as if under examination.

(e) The formal hearing need not be conducted according to technical rules relating to evidence and witnesses.

(1) Relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions.

(2) Hearsay evidence shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

(3) The rules of privilege shall be effective to the same extent that they are now or hereafter may be recognized in civil actions and irrelevant and unduly repetitious evidence shall be excluded.

(f) The following additional exception to the "best evidence" rule (Evidence Code Section 1500) applies:

(1) A duplicate is admissible to the same extent as an original unless:

(A) A genuine question is raised as to the authenticity of the original or the duplicate.

- (B) It would be unfair to admit the duplicate in lieu of the original.
- (g) A hearing officer may question any party or witness and may admit any relevant and material evidence.
- (h) The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall set forth the order in which evidence will be received.
- (i) The Department shall present its audit findings and evidence first at the hearing. The Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made. Once the Department has presented such a prima facie case, the burden of proof shifts to the provider to demonstrate, by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.
- (j) The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.
- (k) The hearing shall be conducted in the English language. The proponent of any testimony to be offered by a witness who does not speak the English language proficiently shall provide an interpreter, approved by the hearing officer, proficient in the English language and the language in which the witness will testify, to serve as interpreter during the hearing. The cost of the interpreter shall be paid by the party providing the interpreter.

s 51038. Official Notice.

- (a) The hearing officer shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code. The hearing officer may take official notice of those matters set forth in Section 452 of the Evidence Code.
- (b) Parties present at the formal hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto.
- (c) Each party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer.

s 51039. Continued or Further Hearings.

(a) A hearing officer may continue a formal hearing to another time or place if deemed advisable or upon request and a showing of good cause.

(1) Written notice of the time and place of the continued formal hearing, except as provided herein, shall be in accordance with this article.

(2) Oral notice of the time and place of the continued formal hearing may be given to each party present at the formal hearing. Such oral notice shall be confirmed in writing by the hearing officer subsequent to the formal hearing.

(b) The hearing officer may order a further formal hearing prior to the decision, if the hearing officer deems advisable or on a showing of good cause. Notice shall be given in accordance with Section 51025.

s 51040. Evidence.

(a) In Non-institutional provider cases, notwithstanding any other provision of these regulations, and unless otherwise ordered by the assigned Administrative Law Judge, the parties shall:

(1) Not less than ten (10) calendar days prior to the pretrial conference, file a list of all documents and other items to be offered into evidence at the formal hearing, except for impeachment or rebuttal, with a brief statement following each document describing its substance or purpose and the identity of the sponsoring witness.

(2) Not less than seven (7) calendar days prior to the date on which the formal hearing is scheduled to commence, exchange copies of all documents and other items to be offered into evidence at the formal hearing other than for impeachment or rebuttal. Each proposed exhibit shall be premarked for identification.

(3) Prior to the commencement of the formal hearing, any party proposing to object to the receipt in evidence of any proposed exhibit shall advise the opposing party of such objection. The parties shall confer with respect to any objections in advance of the formal hearing and attempt to resolve them. Failure to comply with the requirements of (1) or (2) above shall constitute a ground for objection to the introduction of undisclosed documents and other items, into evidence other than for impeachment or rebuttal.

(b) In all cases, the hearing officer, in order to obtain additional evidence necessary for the proper determination of the case, may:

(1) Continue the formal hearing and hold the record open for either party to produce additional evidence.

(2) Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any material submitted after the close of the formal hearing shall be made available to both parties and each party shall have the opportunity for rebuttal.

(3) Order a further formal hearing if the nature of the additional evidence or the refutation thereof makes a further hearing desirable.

s 51041. Representation at a Formal Hearing.

(a) A hearing officer or hearing auditor may refuse to allow any person to represent a party in any hearing when the person:

(1) Engages in unethical, disruptive or contemptuous conduct.

(2) Intentionally fails to comply with the proper instructions or orders of the hearing officer or hearing auditor or the provisions of this article.

(b) This section shall not be construed to limit the right of a party or its representative to make evidentiary and procedural objections and state the reasons therefor.

s 51042. Oral Argument and Briefs.

(a) The hearing officer shall grant oral and may grant written argument at the request of any party made prior to the close of the formal hearing. The parties shall be advised as to the time and manner within which written argument is to be filed.

(b) The hearing officer may require any party to submit written memoranda pertaining to any or all issues raised in the formal hearing.

s 51043. Disqualification of Hearing Officer.

(a) A hearing officer shall voluntarily withdraw from any proceedings in which the hearing officer:

(1) Cannot give a fair or impartial hearing.

(2) Has an interest.

(b) A party may request the disqualification of a hearing officer by filing an affidavit stating in detail the grounds upon which it is claimed that a fair and impartial hearing cannot be given or that the hearing officer has an interest in the proceeding. The hearing officer shall immediately present the affidavit to the Chief Counsel of the Department who shall:

(1) Investigate the allegations and advise the complaining party in writing of the decision granting or denying the request to disqualify the hearing officer. A copy of the decision shall be mailed to the other parties. Or

(2) Reassign the case to another hearing officer without investigation.

s 51044. Decision.

(a) The hearing officer shall take the matter under submission at the conclusion of the hearing. A proposed decision, in a form that may be adopted as the decision of the Director, shall be submitted to the Director as soon as practical. A copy of the proposed decision, upon submission to the Director, shall be:

(1) Filed by the Department as a public record.

(2) Served by the Department on each party in the case and each party's representative.

(b) The Director may:

(1) Adopt the proposed decision without reading or hearing the record.

(2) Reject the proposed decision and have a decision prepared based upon the documentary and electronically recorded record, with or without taking additional evidence. The Director shall decide no case provided for in this paragraph without affording the parties the opportunity to present either oral or written argument.

(3) Refer the matter to the hearing officer to take additional evidence. If the case is so assigned, the hearing officer shall prepare a proposed decision as provided in subsection (a), upon the additional evidence and the documentary and electronically recorded record of the prior hearing. A copy of such proposed decision shall be furnished to each party and each party's representative as prescribed in subsection (a).

(c) The decision shall be final upon adoption by the Director. Copies of the decision of the Director shall be mailed by certified mail to the designated representative of the provider.

(d) A dismissal may be issued if a provider fails to appear at a formal hearing. A copy of such dismissal shall be mailed to each party together with a statement of the provider's right to reopen the hearing.

(e) The Director may vacate any dismissal if the provider makes application in writing, within ten calendar days after personal service or receipt of such dismissal, showing good cause for failure to appear at the hearing. Lack of good cause shall be inferred if a continuance of the formal hearing is not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(f) If a party to a formal hearing other than the provider fails to appear at a hearing and the hearing officer issues a decision on the merits adverse to that party's interests, the decision shall be accompanied by a statement of the party's right to make application to vacate the decision. The application may be in writing and shall be made within ten calendar days after personal service or mailing of the decision. Upon a showing of good cause for failure to appear at the hearing, the Director may issue an order to vacate the decision and the matter may be set for further hearing. Lack of good cause will be inferred when a continuance of the hearing was not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(g) The parties shall be given written notice of an order granting or denying any application to vacate a decision.

s 51045. Reconsideration.

(a) The Department may order a reconsideration of all or part of the case on its own motion or on petition of any party. The power to order a reconsideration shall expire 30 calendar days after delivery or mailing of a decision to the provider. The Department may grant a stay of expiration of its power to order reconsideration:

(1) for up to 30 days for the purpose of enabling a party to file a petition for reconsideration; or

(2) for up to 10 days when needed solely for the purpose of considering a petition filed prior to expiration of its power to order reconsideration.

The petition of a party shall be deemed denied if the Department takes no action within the time allowed for ordering reconsideration.

(b) The case may be:

(1) Reconsidered by the Department on all the pertinent parts of the records and such additional evidence and arguments as may be permitted.

(2) Assigned to a hearing officer for further written or oral hearing.

(c) The decision for a reconsideration assigned to a hearing officer shall be subject to the procedure provided in section 51044.

s 51046. Judicial Review.

s 51047. Recovery of Overpayments.

(a) When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment. The overpayment shall be recovered by any of the following methods:

(1) Lump sum payment by the provider.

(2) Offset against current payments due to the provider.

(3) A repayment agreement executed between the provider and the Department.

(4) Any other method of recovery available to and deemed appropriate by the Director.

(b) An offset against current payments shall continue until one of the following occurs:

(1) The overpayment is recovered.

(2) The Department enters into an agreement with the provider for repayment of overpayment.

(3) The Department determines, as a result of proceedings under this article, that there is no overpayment.

(c) The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).

(d) Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.

(e) Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest computed at

the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f) As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

s 51048. Administrative Review of Performance Under Selective Provider Contracts.

(a) As an alternative to judicial review pursuant to Welfare and Institutions Code Section 14087.27(a), administrative review of disputes between a contracting hospital and the state relating to performance under the Selective Provider Contracting Program shall be heard by an independent hearing examiner appointed by the Director of the Department of Health Services.

(b) The independent hearing examiner shall conduct an administrative hearing and render a proposed decision to be adopted by the Director pursuant to the applicable procedural requirements of Article 1.5, Provider Audit Appeals (Sections 51016-51047) with the following exceptions:

(1) There shall be no exit conference or informal hearings.

(2) All references to a hearing officer shall apply to the independent hearing examiner appointed by the Director pursuant to Welfare and Institutions Code Section 14087.27.

s 51048.1. Limitations.

(a) A skilled nursing and/or intermediate care facility Medi-Cal provider may, in accordance with the regulations contained in Sections 51048.2 through 51048.8, appeal the decision of the Department that a facility is not qualified to participate in the Medi-Cal program.

(b) The Department in rendering its determination shall set forth the pertinent facts and conclusions upon which the determination is made, and shall notify the provider of its right to appeal under subdivision (a).

(c) The effective date of a determination rendered under this article is as follows:

(1) A determination not to renew a certification is effective on the date the existing certification actually expires.

(2) A determination to deny a certification is effective upon the receipt of the determination by the provider, except, if the provider files a request for reconsideration under Section 51048.3, the determination shall be effective upon receipt of the reconsidered determination by the provider.

(d) These appeal processes are only available to Medi-Cal providers of skilled nursing facilities who do not participate in the Medicare program. Providers who participate in both Medi-Cal and Medicare may appeal certification decisions to the Department of Health and Human Services in accordance with 42 CFR, 405.1501 et seq. A final decision rendered pursuant to 42 CFR 405.1501 et seq. is binding for purposes of Medi-Cal participation.

s 51048.2. Right to a Reconsideration.

(a) A skilled nursing and/or intermediate care facility provider who disagrees with a determination that the skilled nursing or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, in accordance with Section 51048.3, request that the Department reconsider that decision.

(b) The reconsideration of a nonrenewal of an existing provider agreement shall be completed prior to the end of the certification period.

(c) The reconsideration of a denial of an initial application for certification shall be made within 30 days of the receipt of the request for a reconsideration.

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(b) The reconsideration of a nonrenewal of an existing provider agreement shall be completed prior to the end of the certification period.

(c) The reconsideration of a denial of an initial application for certification shall be made within 30 days of the receipt of the request for a reconsideration.

s 51048.3. Request for Reconsideration.

(a) If a provider or authorized representative of the provider requests a reconsideration, the request shall be filed within 15 days after the date of receipt of notice of the determination that the provider does not qualify as a Medi-Cal provider. The request shall be filed with the Director of the Department of Health Services or the designee authorized to accept such requests.

(b) A request for reconsideration shall:

(1) Be in writing.

(2) State the reasons upon which the provider disagrees with the determination.

(3) Include relevant evidence.

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(b) A request for reconsideration shall:

(1) Be in writing.

(2) State the reasons upon which the provider disagrees with the determination.

(3) Include relevant evidence.

s 51048.5. Right to Full Evidentiary Hearing.

(a) A skilled nursing facility or intermediate care facility provider which disagrees with the Department's reconsidered determination that the skilled nursing facility or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, by complying with Section 51048.6 request a full evidentiary hearing or the provider may by-pass the informal reconsideration process and appeal the Department's decision directly to the evidentiary hearing process.

(b) The hearing shall provide an opportunity for the provider to:

(1) Appear before an impartial hearing officer to offer evidence to rebut the Department's determination concerning the provider's ability to render services in the Medi-Cal program.

(2) Be represented by counsel or another representative.

(3) Be heard in person.

(4) Call witnesses.

(5) Present oral and documentary evidence.

(6) Cross-examine witnesses.

s 51048.6. Request for a Full Evidentiary Hearing.

(a) A request for a full evidentiary hearing shall be made in writing and signed by the provider or authorized representative of the skilled nursing facility or intermediate care facility concerned. The request shall be filed:

(1) With the Director, Department of Health Services, or the designee authorized to accept such requests.

(2) Within 15 days after the date the notice of the determination or reconsidered determination is received by the provider.

(b) A request for hearing shall contain:

(1) A statement as to the specific issues in the preceding determination with which the provider disagrees.

(2) The basis for provider's contention that the determination is incorrect.

(c) The provider or authorized representative of the skilled nursing facility or intermediate care facility shall bear sole responsibility for filing the request for full evidentiary hearing.

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(a) A request for a full evidentiary hearing shall be made in writing and signed by the provider or authorized representative of the skilled nursing facility or intermediate care facility concerned. The request shall be filed:

(1) With the Director, Department of Health Services, or the designee authorized to accept such requests.

(2) Within 15 days after the date the notice of the determination or reconsidered determination is received by the provider.

(b) A request for hearing shall contain:

(1) A statement as to the specific issues in the preceding determination with which the provider disagrees.

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(b) A request for hearing shall contain:

(1) A statement as to the specific issues in the preceding determination with which the provider disagrees.

(2) The basis for provider's contention that the determination is incorrect.

(c) The provider or authorized representative of the skilled nursing facility or intermediate care facility shall bear sole responsibility for filing the request for full evidentiary hearing.

s 51048.9. Remedies Other Than Termination.

(a) The Department may impose a remedy other than or in addition to termination of a provider as provided in Section 1919(h)(2) of the Social Security Act. (Section 1396r(h)(2) of Title 42 of the United States Code).

(b) In deciding what remedy to impose, the Department shall select the remedy using the factors and standards contained in subpart F (commencing with section 488.400) of part 488 of subchapter E of chapter IV of Title 42 of the Code of Federal Regulations.

(c) The provisions of this Article shall apply to facility appeals of remedies other than termination.

s 51050. Health Care Financing Administration's Common Procedure Coding System.

Health Care Financing Administration's Common Procedure Coding System (HCPCS) means a coded listing and description of health care services and items prepared and updated annually by the U.S. Health Care Financing Administration. HCPCS consists of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, and other codes and descriptions authorized by the Health Care Financing Administration to describe services and items not contained in the CPT. HCPCS is used by all Medicare and Medicaid Programs nationwide to identify and describe covered benefits under their respective programs. To the extent not elsewhere adopted in these regulations, HCPCS, and each of its subsequent updates, is herein incorporated by reference into these regulations.

EDITORIAL NOTE: Pursuant to the provisions of Title 1 of the California Administrative Code, Section 20, this regulation is not printed in full herein. The Health Care Financing Administration's Common Procedure Coding System, and each of its annual updates, may be examined at the Department of Health Services, Benefits Branch, 714 P Street, Sacramento. It is published in two separate documents. Copies of the HCPCS Level II Code Book can be purchased from St. Anthony Publishing, Inc., P.O. Box 96561, Washington, DC 20090. Copies of the CPT can be purchased from the American Medical Association by calling 800-621-8335.

s 51051. Provider.

(a) "Provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.

(b) Providers include, but are not limited to:

Acupuncturists

Audiologists

Blood Banks

Child Health and Disability Prevention Providers

Chiropractors

Christian Science Facilities

Christian Science Practitioners

Clinical Laboratories or Laboratories

Comprehensive Perinatal Providers

Dental School Clinics

Dentists

Dispensing Opticians

Durable Medical Equipment and Medical Supply Providers

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Providers

EPSDT Supplemental Services Providers

Fabricating Optical Laboratory

Hearing Aid Dispensers

Home Health Agencies Hospices

Hospital Outpatient Departments

Hospitals

Intermediate Care Facilities

Intermediate Care Facilities for the Developmentally Disabled

Licensed Midwife

Local Educational Agency Providers

Nurse Anesthetists

Nurse Midwives

Nurse Practitioners

Nursing Facilities

Occupational Therapists

Ocularists Optometrists

Orthotists

Organized Outpatient Clinics

Outpatient Heroin Detoxification Providers

Personal Care Service Providers

Pharmacies/Pharmacists

Physical Therapists

Physicians

Podiatrists

Portable X-ray Services

Prosthetists

Providers of Medical Transportation

Psychologists Rehabilitation

Centers Renal Dialysis Centers and Community Hemodialysis Units

Respiratory Care Practitioners

Rural Health Clinics

Short-Doyle Medi-Cal Providers

Skilled Nursing Facilities

Speech Therapists

Targeted Case Management Providers

s 51052. Blood Bank.

"Blood bank" means a facility that collects, stores, and distributes human blood and blood derivatives.

s 51053. Physician.

"Physician" means a doctor of medicine or osteopathy.

s 51055. Physicians' Services.

"Physicians' services" means professional services performed or provided by physicians, including, but not limited to, surgery, anesthesiology, radiology, consultations, and home, office and institutional calls.

s 51056. Emergency Services.

(a) Except as provided in subsection (b), "emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(b) For purposes of providing treatment of an emergency medical condition to otherwise eligible aliens pursuant to Welfare and Institutions Code Section 14007.5(d), "emergency medical condition" means 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.

(c) Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

(1) Any service classified as an emergency, which would have been subject to prior authorization had it not been so classified, must be supported by a physician's, podiatrist's, dentist's, or pharmacist's statement which describes the nature of the emergency, including relevant clinical information about the patient's condition, and states why the emergency services rendered were considered to be immediately necessary. A mere statement that an emergency existed is not sufficient. It must be comprehensive enough to support a finding that an emergency existed. Such statement shall be signed by a physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency described in this statement.

(A) The provision for pharmacist certification of emergency services shall pertain only to the dispensing of drugs.

(2) The Department may impose postservice prepayment audit as set forth in Section 51159(b), to review the medical necessity of emergency services provided to beneficiaries. The Department may require providers to follow the procedures for obtaining authorization on a retroactive basis as the process for imposing postservice prepayment audits. Requests for retroactive authorization of emergency services must adequately document the medical necessity of the services and must justify why the services needed to be rendered on an emergency basis.

(d) Program limitations set forth in Sections 51304 and 51310 are not altered by this section.

s 51056.1. Experimental Services.

(a) Experimental services means those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.

(b) Investigational services means those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but:

- (1) Testing is not complete; and
- (2) The efficacy and safety of such services in human subjects are not yet established; and
- (3) The service is not in wide usage.

(c) The determination that a service is experimental or investigational is based on:

- (1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);

- (2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;

- (3) Reference to current medical literature.

s 51056.2. Unlabeled Use of Drugs.

Unlabeled use of drugs means the use of an already marketed drug for a clinical indication not listed in the approved labeling of the drug by the U.S. Food and Drug Administration.

s 51057. Dentist.

"Dentist" means a doctor of dental surgery (D.D.S.), dental medicine (D.M.D.), or dental science (D.D.Sc.).

s 51059. Dental Services.

"Dental services" means professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the

alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.

s 51060. Dental School Clinic.

"Dental school clinic" means an organized unit which, under the management of a dental school, provides dental services.

s 51061. Emergency Dental Services.

s 51063. Diagnostic Dental Services.

s 51065. Restorative Dental Services.

s 51066. Orthodontic Dental Services.

s 51067. Registered Nurse.

"Registered nurse" means any person having a current license to practice in California issued by the Board of Registered Nursing.

s 51069. Licensed Vocational Nurse.

Licensed Vocational Nurse means any person having a current license to practice vocational nursing in California issued by the Board of Vocational Nurse Examiners.

s 51070. Psychiatric Technician.

s 51071. Chiropractor.

"Chiropractor" means a doctor of chiropractic.

s 51073. Chiropractic Services.

Chiropractic services means services a chiropractor may perform under California laws limited to treatment involving manual manipulation of the spine.

s 51073. Chiropractic Services.

Chiropractic services means services a chiropractor may perform under California laws limited to treatment involving manual manipulation of the spine.

s 51074.5. Acupuncture Services.

"Acupuncture services" means the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.

s 51075. Podiatrist.

"Podiatrist" means a doctor of surgical chiropody (D.S.C.), doctor of podiatric medicine (D.P.M.), doctor of surgical podiatry (D.S.P.), or doctor of podiatry (D.P. or Pod. D.).

s 51077. Podiatry Services.

"Podiatry Services" means services a podiatrist may perform under California laws.

s 51079. Physical Therapist.

"Physical Therapist" means a person trained to practice physical therapy.

s 51081. Physical Therapy.

"Physical therapy" means treatment prescribed by a physician, dentist or podiatrist of any bodily condition by the use of physical, chemical and other properties of heat, light, water, electricity or sound, and by massage and active, resistive or passive exercise.

s 51082. Respiratory Care Practitioner.

(a) A respiratory care practitioner is a person trained and licensed as specified in Business and Professions Code section 3700 et seq., while acting within the scope of practice for respiratory care providers authorized by California law, to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems.

(b) Respiratory care practitioners must meet the standards for participation in the Medi-Cal program as specified in section 51225.5 to implement the written or verbal orders of a physician pertaining to the practice of respiratory care.

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(b) Respiratory care practitioners must meet the standards for participation in the Medi-Cal program as specified in section 51225.5 to implement the written or verbal orders of a physician pertaining to the practice of respiratory care.

s 51083. Occupational Therapist.

s 51085. Occupational Therapy.

"Occupational therapy" means services prescribed by a physician, dentist or podiatrist to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced age.

s 51087. Dietitian.

s 51089. Dietitian's Services.

s 51090. Dispensing Optician.

"Dispensing optician" means an individual or firm which fills prescriptions of physicians for prescription lenses and kindred products and fits and adjusts such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses.

s 51091. Optometrist.

"Optometrist" means a doctor of optometry.

s 51093. Optometric Services.

"Optometric Services" means any services an optometrist may perform under the laws of this state.

s 51094. Hearing Aid Dispenser.

"Hearing aid dispenser" means a person engaged in the fitting or selling of hearing aids to an individual with impaired hearing.

s 51094.1. Hearing Aid.

Hearing aid means any aid prescribed as specified in Section 51319 for the purpose of aiding or compensating for impaired human hearing loss.

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Hearing aid means any aid prescribed as specified in Section 51319 for the purpose of aiding or compensating for impaired human hearing loss.

s 51097. Audiologist.

"Audiologist" means a person who performs procedures of measurement, appraisal, identification and counseling related to hearing and disorders of hearing; provides rehabilitation services for the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and recommends and evaluates hearing aids.

s 51098. Audiological Services.

"Audiological services" means services for: the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids.

s 51098.5. Sign Language Interpreter Services.

(a) Sign language interpreter services means those services specified in Section 51309.5, which are provided by a Certified or Non-Certified interpreter, who meets the standards set forth in Section 51202.5, to facilitate effective communication between:

(1) a deaf or hearing-impaired Medi-Cal beneficiary and a Medi-Cal enrolled physician or a member of a Medi-Cal enrolled physician group during the course of a medical examination or other procedure, or

(2) a deaf or hearing impaired adult and a Medi-Cal enrolled physician or a member of a Medi-Cal enrolled physician group on behalf of a beneficiary, when necessary to facilitate the provision of medically necessary services.

s 51099. Psychologist.

"Psychologist" means a person trained in the assessment, treatment, prevention, and amelioration of emotional and mental health disorders.

s 51100. Psychologist Services.

s 51101. Orthotist.

"Orthotist" means a person who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

s 51102. Ocularist.

"Ocularist" means a person who is trained to design, fabricate, and fit artificial eyes.

s 51103. Prosthetist.

"Prosthetist" means a person who makes and fits artificial limbs or other parts of the body.

s 51104. Durable Medical Equipment and Medical Supply Providers.

"Durable Medical Equipment and Medical Supply Providers" means individuals or entities identified as assistive device and sickroom supply dealers in Welfare and Institutions Code, Section 14105.2 who furnish the following:

(a) Durable medical equipment, as defined in Section 51160.

(b) Medical supplies, covered in accordance with Section 51320 and reimbursed in accordance with Section 51520.

(c) Incontinence medical supplies, as defined in Section 14125.1 of the Welfare and Institutions Code.

s 51104.1. Incontinence Medical Supply Dealer.

"Incontinence Medical Supply Dealer" means any person, partnership, corporation, or other entity that is a retailer who maintains an inventory of and is an outlet for incontinence medical supplies, and who provides these supplies directly to the general public.

s 51105. Pharmacist.

"Pharmacist" means a doctor of pharmacy (Pharm.D.), Bachelor of Science in Pharmacy (B.S.), or a person trained to practice pharmacy in an accredited college of pharmacy or an approved apprentice program prior to 1937.

s 51106. Pharmacy.

"Pharmacy" is a facility where a pharmacist stores, compounds, and dispenses drugs.

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"Pharmacy" is a facility where a pharmacist stores, compounds, and dispenses drugs.

s 51108. Inpatient.

"Inpatient" means a person who has been admitted to a hospital, skilled nursing facility, or intermediate care facility for bed occupancy for purposes of receiving inpatient

services. A person is considered an inpatient when he is formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed, even though it later develops that he can be discharged or that he is transferred to another facility and does not actually use a bed overnight.

s 51109. Hospital.

"Hospital" means any institution, place, building, or agency which meets the standards specified in Section 51207 of these regulations and which maintains and operates organized facilities for one or more persons for the diagnosis, care and treatment of human illness, which may include convalescence and care during and after pregnancy, or which maintains and operates organized facilities for any such purpose, and to which persons may be admitted for overnight stay or longer.

s 51110. Hospital Acute Care.

(a) "Hospital acute care" means those services provided by a hospital to patients who need, or must have available the facilities, services, and equipment described in Section 51207 for prevention, diagnosis, or treatment of illness or injury.

(b) The determination of need for acute care shall be made in accordance with Sections 51003 and 51327.

(c) An acute care patient able to reasonably sustain a transport in an Emergency Medical Technician I (EMT-1) staffed ambulance, with no expected increase in morbidity or mortality, shall be considered stable for the purpose of transport.

s 51110.1. Hospital Extended Care.

s 51110.2. Hospital Long-Term Care.

s 51110.3. Hospital Extended Care Facility.

s 51110.4. Hospital Intermediate Care.

s 51111. Inpatient Hospital Services.

"Inpatient Hospital Services" include the following services furnished by a hospital:

(a) Bed and board;

(b) Nursing and related services, use of hospital facilities, medical social services ordinarily furnished by the hospital, and such drugs, biologicals, supplies, appliances and equipment, as are ordinarily furnished by the hospital;

(c) Other diagnostic and therapeutic services ordinarily furnished by the hospital, exclusive of physicians' services;

(d) Medical and surgical services performed by interns and residents-in-training, as defined in Section 1861 (b) of Title XVIII of the Federal Social Security Act; and

(e) Administrative services performed by physicians for the hospital.

s 51112. Hospital Outpatient Department.

"Hospital outpatient department" means a hospital unit which provides services for the prevention, diagnosis, and treatment of disease, illness, or injury to outpatients.

s 51113. Hospital Outpatient Department Services.

"Hospital outpatient department services" means diagnostic, preventive or therapeutic services furnished on an outpatient basis on the premises of a hospital. Hospital based home health agency services, home dialysis services, portable X-ray services, and collection of laboratory specimens need not be furnished on the premises of the facility.

s 51115. Organized Outpatient Clinic.

(a) "Organized outpatient clinic" means a medical care facility that is established, organized, and licensed pursuant to Section 406, Title 17, California Administrative Code, and which provides services for the prevention, diagnosis and treatment of disease, illness or injury on an outpatient basis, and which is not part of a hospital.

(b) "Organized outpatient clinic with surgical facilities" means an organized outpatient clinic which conforms to the standards established in Title 17, California Administrative Code, Section 425(c)(4)(A) and (B).

s 51115.1. Organized Outpatient Clinic Services.

(a) "Organized Outpatient Clinic Services" means preventive, diagnostic, therapeutic, and rehabilitative services that are:

(1) Provided to outpatients;

(2) Provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

(3) Except in the case of certified nurse-midwife services, furnished by or under the direction of a physician or dentist.

(b) A clinic may not provide patients with room and board and professional services on a continuous 24-hour-a-day basis.

(c) Eligibility for clinic services is limited to those patients:

(1) Who for the purpose of receiving necessary health care go or are brought to a clinic;

(2) Who receive services in the clinic;

(3) Who within a 24-hour period leave the clinic site at which the services are provided.

s 51115.5. Rural Health Clinic.

"Rural health clinic" means an organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

s 51115.6. Rural Health Clinic Services.

"Rural health clinic services" means preventative, diagnostic, therapeutic, rehabilitative or treatment services, including, but not limited to, primary care services provided by a rural health clinic.

s 51115.7. Rural Shortage Area.

"Rural shortage area" means a census tract designated by the Secretary, Department of Health and Human Services, as rural and deficient in personal health services or primary medical manpower.

s 51116. Outpatient Heroin Detoxification Services.

(a) "Outpatient detoxification services" means the administering or furnishing by a physician, or under the ongoing supervision of a physician, either of the following:

(1) Methadone as a substitute narcotic drug in decreasing doses to reach a diminished or drug free state in a period not to exceed 21 days.

(2) Nonnarcotic drugs to reduce or eliminate, over a period not to exceed 21 days, an individual's dependence on heroin or other morphine-like drugs.

s 51117. Rehabilitation Center.

"Rehabilitation center" means a facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.

s 51118. Intermediate Care Facility.

"Intermediate care facility" means a facility which is licensed as such by the Department or is a hospital or skilled nursing facility which meets the standards specified in Section

51212 and has been certified by the Department for participation in the Medi-Cal program.

s 51119. Rehabilitation Services.

s 51120. Intermediate Care Services.

(a) Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:

(1) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.

(2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.

(3) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

(b) With respect to services furnished to individuals under age 65, intermediate care services may include services in a public institution (or distinct part thereof) for mentally retarded or persons with related conditions only if:

(1) The primary purpose of such institution (or distinct part thereof) is to provide a program of health or rehabilitative services for mentally retarded individuals and such institutions meet standards as may be prescribed by the United States Department of Health and Human Services.

(2) The mentally retarded individual with respect to whom a request for payment is made has been determined to need and is receiving active treatment under such a program.

(3) Payment for intermediate care services to any such institution (or distinct part thereof) will not be used to displace with Federal funds any non-Federal expenditures that are already being made for mentally retarded persons.

(c) Intermediate care services do not include:

(1) Services rendered in accordance with Section 51305, Physician Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services; 51310, Podiatry Services; 51311, Laboratory, Radiological, and Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Prosthetic Eyes, and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies; 51321, Durable Medical Equipment, except as provided in Section 51321 (h) (4); 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Heroin Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal Homotransplantation; 51331, Hospital Outpatient Department Services and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle Medi-Cal Provider Services.

(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal Consultant and which are therefore separately billed by other providers of services; nor

(3) Personal care items and services not reimbursable by the California Medical Assistance Program as a medical care service but for which a personal and incidental allowance is provided.

s 51120.5. Nursing Facility.

Nursing facility means a facility that is licensed as either a skilled nursing facility or an intermediate care facility.

s 51121. Skilled Nursing Facility Services.

(a) Skilled nursing facility means any institution, place, building, or agency which is licensed as a skilled nursing facility by the Department or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and

has been certified by the Department for participation as a skilled nursing facility in the Medi-Cal program

(b) As used in this chapter and defined in this section, the term "skilled nursing facility" shall include the terms "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility."

s 51123. Skilled Nursing Facility Services.

(a) Skilled nursing facility services include:

(1) Room and board.

(2) Nursing and related care services.

(3) Commonly used items of equipment, supplies and services used for the medical and nursing benefit of patients as set forth in 51511 (b).

(b) Skilled nursing facility services do not include:

(1) Services rendered in accordance with Section 51305, Physician's Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services; 51310, Podiatry Services; 51311, Laboratory, Radiological, and Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Prosthetic Eyes, and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies, other than those described under (a) (3) above; 51321, Durable Medical Equipment, other than those described under (a) (3) above; 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Heroin Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal Homotransplantation; 51331, Hospital Outpatient Department Services and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle Medi-Cal Provider Services.

(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal consultant and which are therefore separately billed by other providers of services.

(c) Skilled nursing facility services do not include items and services which are provided under State Department of Social Services regulations.

s 51124. Skilled Nursing Facility Level of Care.

(a) "Skilled Nursing facility level of care" means that level of care provided by a skilled nursing facility meeting the standards for participation as a provider under the Medi-Cal program as set forth in Section 51215 of this division.

(b) The skilled nursing facility level of care is the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses, or the equivalent thereof, as set forth in Section 51215.

(c) Skilled nursing care provided in participating skilled nursing facilities is the composite of necessary observation, assessment, judgment, supervision, documentation, and teaching of the patient and includes specific tasks and procedures.

(d) Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's orders, and are either performed or supervised by a licensed registered nurse, a licensed vocational nurse or in the case of institutions for mentally retarded or distinct parts of institutions which are certified as skilled nursing facilities and providing care for mentally retarded patients, by a licensed psychiatric technician. A need for one or more skilled nursing procedures does not necessarily indicate a medical need for skilled nursing facility services. Rather, the need must be for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following: administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions; gastric tube or gastrostomy feedings; nasopharyngeal aspiration; insertion or replacement of catheters; application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders; heat treatments which require observation by licensed personnel to evaluate the patient's progress; administration of medical gases under prescribed therapeutic regimen; and restorative nursing procedures which require the presence of a licensed nurse.

(e) Other health care services, such as physical, occupational or speech therapy, require specialized training for proper performance. The need for such therapies does not necessarily indicate a need for nursing facility services.

s 51124.1. Transitional Inpatient Level of Care.

s 51124.1. Transitional Inpatient Level of Care.

s 51124.2. Medi-Cal Care Coordinator.

"Medi-Cal Care Coordinator" means the designated Medi-Cal consultant who authorizes, reauthorizes, and coordinates, as required, medically necessary services for a beneficiary. The Medi-Cal Care Coordinator shall be a physician or registered nurse. The extent of the participation of the Medi-Cal Care Coordinator is determined by the complexity and multiplicity of service needs of the patient. The Medi-Cal Care Coordinator shall work, as required, with the physicians, the facility discharge coordinators, preadmission screeners and other facility personnel, as required, to coordinate and authorize those services needed by the patient and which are authorized by the Medi-Cal Program.

s 51124.5. Subacute Level of Care.

(a) Subacute level of care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

(b) To be eligible for subacute level of care a patient's condition shall meet all of the criteria as provided for in the Subacute Level of Care Criteria contained in the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, California Code of Regulations (CCR), Section 51003(e) as determined by the patient's attending physician and as approved by the appropriate Medi-Cal field office medical consultant or equivalent authorizing agent, who is responsible for authorizing the level of care.

s 51124.6. Pediatric Subacute Care Services.

(a) Pediatric subacute care services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

(b) Medical necessity for pediatric subacute care services shall be substantiated by any one of the following items in (1) through (4) below:

(1) A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day;

(2) Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in (B) through (E) below:

(A) Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;

(B) Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion;

(C) Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;

(D) Dependence on tube feeding, naso-gastric or gastrostomy tube;

(E) Dependence on other medical technologies required continuously, which in the opinion of the attending physician and the Medi-Cal consultant require the services of a professional nurse.

(3) Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;

(4) Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (b)(2)(A) through (E) above.

(c) Medical necessity for pediatric subacute skilled nursing care shall be further substantiated by all of the following conditions:

(1) The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the patient's healthcare needs, and not be any less than the nursing staff ratios specified in Section 51215.8(g) and (i);

(2) The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary;

(3) The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

s 51124.7. Preceptorship.

"Preceptorship", as referenced in Section 51215.8(k), means a one-to-one teaching relationship wherein a registered nurse meeting the qualifications specified in Section 51215.8(j) works with a licensed nurse, as specified in Section 51215.8(k)(2), to enhance the licensed nurse's clinical competency in providing nursing services to the types of pediatric patients with technology dependency for whom the facility provides care.

s 51125. Home Health Agency.

s 51127. Coordinated Home Care.

s 51128. Specialized Rehabilitative Services in Skilled Nursing Facilities or Intermediate Care Facilities.

"Specialized rehabilitative services" means physical therapy, occupational therapy, speech therapy or audiology services furnished to inpatients of skilled nursing or intermediate care facilities by providers meeting the standards set forth in Article 3 of these regulations.

s 51129. Home Health Agency Services.

s 51131. Home Nursing Services.

s 51132. Short-Doyle Medi-Cal Providers.

"Short-Doyle Medi-Cal providers" means any agency, individual, organization, or facility which has been approved by the Department to participate in the Short-Doyle Medi-Cal program.

s 51133. Home Health Aide Services.

s 51134. Short-Doyle Medi-Cal Provider Services.

"Short-Doyle Medi-Cal provider services means those community mental health services covered by the Short-Doyle Act which are provided by a Short-Doyle Medi-Cal provider.

s 51135. Healing by Prayer or Spiritual Means.

"Healing by prayer or spiritual means" means services of Christian Science Practitioners.

s 51136. Christian Science Facility.

s 51137. Laboratory.

s 51137.1. Clinical Laboratory or Laboratory.

"Clinical Laboratory" or "Laboratory" means any place used, organized, or operated, for the examination, detection, identification, measurement, or enumeration of any particular entity or substance, which consists of materials derived from the human body for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings, or used as an aid in the prevention, prognosis, monitoring, or treatment of a physiological or pathological condition in a human being.

s 51137.1. Clinical Laboratory or Laboratory.

"Clinical Laboratory" or "Laboratory" means any place used, organized, or operated, for the examination, detection, identification, measurement, or enumeration of any particular entity or substance, which consists of materials derived from the human body for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings, or used as an aid in the prevention, prognosis, monitoring, or treatment of a physiological or pathological condition in a human being.

s 51139. Radiological and Radioisotope Services.

Radiological and Radioisotope Services means diagnostic and therapeutic X-ray and radioisotope services.

s 51139. Radiological and Radioisotope Services.

Radiological and Radioisotope Services means diagnostic and therapeutic X-ray and radioisotope services.

s 51142. Inpatient Services.

"Inpatient services" means preventive diagnostic, or treatment services provided in a hospital, skilled nursing facility, or intermediate care facility to a patient who is a registered inpatient in that facility.

s 51143. Outpatient Services.

"Outpatient services" means preventive, diagnostic, or treatment services other than inpatient services.

s 51145. Home.

For the purposes of providing home health agency services, home means any place of residence of a beneficiary, other than while a registered inpatient of a hospital or skilled nursing facility or intermediate care facility.

s 51145.1. "Home" Defined for the Personal Care Services Program.

For purposes of Section 51350(b), "home" means that place in which the beneficiary chooses to reside. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her "home". The beneficiary's "home" does not include a board and care facility, a facility licensed by the California State Department of Health Services nor a community care facility or a residential care facility licensed by the California State Department of Social Services.

s 51146. Homebound Patient.

A homebound patient is defined as one who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration; e.g. for a short walk prescribed as therapeutic exercise.

s 51147. Medical Social Work or Medical Social Services.

Medical Social Work or Medical Social Services, as referred to in Section 51125 and 51129 means professional services, provided by a person with a master's degree from a recognized school of social work, to assist individuals and groups in their efforts to solve medical-social problems that arise as a result of their illness or disabilities.

s 51149. Social Work Services.

s 51151. Medical Transportation Services.

"Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, litter vans or wheelchair vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.

s 51151.1. Ambulance.

"Ambulance" means a vehicle specially constructed, modified, equipped and used for the purpose of transporting sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons.

s 51151.2. Ambulance Patient.

"Ambulance patient" means a patient whose medical condition requires the specialized services, equipment and personnel available in an ambulance.

s 51151.3. Litter Van.

"Litter van" means a vehicle which is modified, equipped and used for the purpose of providing nonemergency medical transportation for those patients with stable medical conditions who require the use of a litter or gurney and which is not routinely equipped with the medical equipment or personnel required for the specialized care provided in an ambulance.

s 51151.4. Litter Van Patient.

"Litter van patient" means a patient whose medical condition is such that the patient may be transported by a litter van.

s 51151.5. Wheelchair Van.

"Wheelchair van" means a vehicle which is modified, equipped and used for the purpose of providing nonemergency medical transportation for wheelchair van patients and which is not routinely equipped with the medical equipment or personnel required for the specialized care provided in an ambulance.

s 51151.6. Wheelchair Van Patient.

s 51151.7. Nonemergency Medical Transportation.

"Nonemergency medical transportation" means transportation by ambulance, litter van and wheelchair van of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons whose medical conditions require medical transportation services but do not require emergency services or equipment during transport.

s 51152. Provider of Medical Transportation.

"Provider of medical transportation" means an individual or organization furnishing medical transportation services as defined in Section 51151.

s 51154. Renal Dialysis Center.

"Renal dialysis center" means a facility which provides chronic hemodialysis and evaluates and treats renal disease.

s 51155. Community Hemodialysis Unit.

"Community hemodialysis unit" means a facility which provides chronic hemodialysis and supervision of patients undergoing chronic home hemodialysis.

s 51156. Renal Homotransplantation Center.

"Renal homotransplantation center" means a hospital at which renal homotransplantation is performed and which provides or has available the supportive personnel and services required to perform renal homotransplantation.

s 51157. Renal Dialysis, Renal Homotransplantation and Related Services.

(a) "Renal dialysis" means removal by artificial means of waste products normally excreted by the kidneys. Such removal may be accomplished by the use of an artificial kidney or peritoneal dialysis on a continuing basis.

(b) "Renal homotransplantation" means the implantation of a kidney from one person to another for the treatment of renal disease.

(c) "Related services" means hospital inpatient and physician's services related to the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis, and dialysis related laboratory tests, medical supplies, and drugs.

s 51158. Nurse Anesthetist.

Nurse Anesthetist means a registered nurse who has completed a course of training in a School of Anesthesia accredited by the American Association of Nurse Anesthetists.

s 51159. Utilization Controls.

Utilization controls that may be applied to services set forth in this chapter include:

(a) Prior authorization, which is approval in advance of the rendering of service of the medical necessity and program coverage of the requested services, by a Department of Health consultant or PCCM plan. In determining what services shall be subject to prior authorization, the Director shall consider factors which include, but are not limited to:

(1) Whether the services to be controlled are generally considered to be elective procedures.

(2) Whether other physician procedures not subject to prior authorization are sufficient in scope and number to afford beneficiaries reasonable access to necessary health care services.

(3) The level of program payment for procedures.

(4) The cost effectiveness of applying prior authorization as a utilization control.

(b) Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

(c) Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

(d) Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

s 51159.1. Peer Review.

The Department may request peer review of provider claims or practices by medical, pharmaceutical or other professional associations or societies. The recommendations of the peer review body to the Department shall be advisory but shall be carefully considered by the Department.

s 51160. Durable Medical Equipment.

Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient that:

(a) Can withstand repeated use.

(b) Is used to serve a medical purpose.

(c) Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.

(d) Is appropriate for use in or out of the patient's home.

s 51161. Prosthetic and Orthotic Appliances.

Prosthetic and orthotic appliances means those appliances prescribed by a physician, dentist or podiatrist for the restoration of function or replacement of body parts.

s 51162. Eyeglasses, Prosthetic Eyes, and Other Eye Appliances.

Eyeglasses, prosthetic eyes and other eye appliances means those items prescribed by a physician or optometrist for medical conditions related to the eye.

s 51162.1. Fabricating Optical Laboratory.

"Fabricating optical laboratory" means a laboratory which surfaces, cuts and edges ophthalmic lenses; fabricates eye appliances as specified in Section 51519.2; and has entered into an exclusive area negotiated contract with the Department of Health Services. An "exclusive area negotiated contract" means a non-bid contract let under the statutory authority of Section 14105.3 of the Welfare and Institutions Code which allows the Department to purchase ophthalmic appliances for Medi-Cal beneficiaries living in a designated geographic area from a specific fabricating optical laboratory.

s 51163. Human Reproductive Sterilization.

(a) Human reproductive sterilization means any medical treatment, procedure or operation, for the purpose of rendering an individual permanently incapable of reproducing.

(b) In this section, and in Sections 51305.1 through 51305.6, "sterilization" means human reproductive sterilization.

s 51164. Intermediate Care Facility for the Developmentally Disabled.

Intermediate care facility for the developmentally disabled means a facility which:

(a) Meets the provisions of Section 76079 of Title 22 of the California Administrative Code, and

(b) Has as its primary purposes, the furnishing of health 24-hour developmental, training and habilitative, and supportive health services to persons with a developmental disability as defined in Welfare and Institutions Code Section 4512.

s 51164.1. Intermediate Care Facility for the Developmentally Disabled Habilitative.

(a) Intermediate care facility for the developmentally disabled habilitative means a facility which:

(1) Has as its primary purposes, the furnishing of 24-hour personal care, developmental, training and habilitative, and supportive health services in a facility with 15 beds or less to residents with a developmental disability. Developmental disability is a disability which originates before age 18 and is a permanent substantial handicap as defined in Welfare and Institutions Code Section 4512.

(2) Provides services to the developmentally disabled in the least restrictive community type setting.

s 51164.2. Intermediate Care Facility for the Developmentally Disabled-Nursing.

Intermediate care facility for the developmentally disabled-nursing means a facility which:

(a) Has as its primary purpose, the furnishing of 24-hour nursing supervision, personal care, training and habilitative services in a facility with 4-15 beds to medically fragile developmentally disabled beneficiaries, or to beneficiaries who demonstrate a significant developmental delay that may lead to a developmental disability if not treated. Such beneficiaries shall have been certified by a physician as not requiring continuous skilled nursing care. Developmental disability is a disability as defined in Welfare and Institutions Code Section 4512.

(b) Provides services to medically fragile developmentally disabled beneficiaries in the least restrictive community setting.

s 51165. Intermediate Care Facility Services for the Developmentally Disabled.

(a) Intermediate care facility services for the developmentally disabled means those services provided in intermediate care facilities for the developmentally disabled, pursuant to the provisions of Sections 76301 through 76413 of Title 22 of the California Administrative Code, except as indicated in (b).

(b) Intermediate care facility services for the developmentally disabled except as reimbursed under Section 51510.1 do not include:

(1) Services rendered in accordance with Section 51305, Physicians' Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy and Audiological Services; 51310, Podiatry Services; 51311, Laboratory, Radiological and Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies; 51321, Durable Medical Equipment, except as provided in Section 51321(h)(4); 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal Homotransplantation; 51331, Hospital Outpatient Department and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle/Medi-Cal Provider Services.

(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal consultant and which are therefore separately billed by other providers of services.

(3) Personal care items and services for which a personal and incidental allowance is provided.

s 51165. Intermediate Care Facility Services for the Developmentally Disabled.

(a) Intermediate care facility services for the developmentally disabled means those services provided in intermediate care facilities for the developmentally disabled, pursuant to the provisions of Sections 76301 through 76413 of Title 22 of the California Administrative Code, except as indicated in (b).

(b) Intermediate care facility services for the developmentally disabled except as reimbursed under Section 51510.1 do not include:

(1) Services rendered in accordance with Section 51305, Physicians' Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy and Audiological Services; 51310, Podiatry Services; 51311, Laboratory, Radiological and

Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies; 51321, Durable Medical Equipment, except as provided in Section 51321(h)(4); 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal Homotransplantation; 51331, Hospital Outpatient Department and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle/Medi-Cal Provider Services.

(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal consultant and which are therefore separately billed by other providers of services.

(3) Personal care items and services for which a personal and incidental allowance is provided.

s 51165. Intermediate Care Facility Services for the Developmentally Disabled.

(a) Intermediate care facility services for the developmentally disabled means those services provided in intermediate care facilities for the developmentally disabled, pursuant to the provisions of Sections 76301 through 76413 of Title 22 of the California Administrative Code, except as indicated in (b).

(b) Intermediate care facility services for the developmentally disabled except as reimbursed under Section 51510.1 do not include:

(1) Services rendered in accordance with Section 51305, Physicians' Services; 51306, Optometry Services; 51307, Dental Services; 51308, Chiropractic Services; 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy and Audiological Services; 51310, Podiatry Services; 51311, Laboratory, Radiological and Radioisotope Services; 51312, Prayer or Spiritual Healing; 51313, Pharmaceutical Services and Prescribed Drugs; 51314, Rehabilitation Center Outpatient Services; 51315, Prosthetic and Orthotic Appliances; 51317, Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances; 51319, Hearing Aids; 51320, Medical Supplies; 51321, Durable Medical Equipment, except as provided in Section 51321(h)(4); 51323, Medical Transportation Services; 51325, Blood and Blood Derivatives; 51326, Nurse Anesthetist Services; 51327, Inpatient Hospital Services; 51328, Outpatient Detoxification Services; 51330, Chronic Hemodialysis; 51330.1, Renal

Homotransplantation; 51331, Hospital Outpatient Department and Organized Outpatient Clinic Services; 51337, Home Health Agency Services; 51340, Early and Periodic Screening Services; and 51341, Short-Doyle/Medi-Cal Provider Services.

(2) Other equipment and supplies for which prior authorizations have been granted to other providers by the Medi-Cal consultant and which are therefore separately billed by other providers of services.

(3) Personal care items and services for which a personal and incidental allowance is provided.

s 51170. Nonphysician Medical Practitioner.

"Nonphysician medical practitioner" means a nurse midwife, physician's assistant, or nurse practitioner who provides primary care.

s 51170.1. Physician's Assistant.

(a) "Physician's assistant" means a person whom the California Board of Medical Quality Assurance has currently:

(1) Certified as a primary health care, women's health care or emergency care physician's assistant.

(2) Approved to perform direct patient care services under the supervision of a primary care physician approved by the Board.

s 51170.2. Nurse Midwife.

"Nurse midwife" means a person who is licensed as a registered nurse and who is currently certified as a nurse midwife by the California Board of Registered Nursing.

s 51170.3. Nurse Practitioner.

(a) "Nurse practitioner" means a licensed registered nurse:

(1) Who is certified by the Board of Registered Nursing as a nurse practitioner.

(2) Whose practice is predominantly that of primary care.

(b) "Certified family nurse practitioner" means a nurse practitioner, as defined in (a), who is authorized or permitted by the Board of Registered Nursing to hold oneself out as a family nurse practitioner and is currently practicing as such.

(c) "Certified pediatric nurse practitioner" means a nurse practitioner, as defined in (a), who is authorized or permitted by the Board of Registered Nursing to hold oneself out as a pediatric nurse practitioner and is currently practicing as such.

s 51170.5. Primary Care.

(a) "Primary care" means health professional services provided in a continuing relationship established with an individual or family group in order to provide:

(1) Surveillance of health needs.

(2) Access to comprehensive health care.

(3) Referral to other health professionals.

(4) Health counseling and patient education.

(b) Primary care is generally provided by those health professionals, including nonphysician medical practitioners, whose practice is predominantly that of general medicine, family practice, internal medicine, pediatrics, obstetrics or gynecology.

s 51171. Physician-Practitioner Interface.

"Physician-Practitioner Interface" means the system of collaboration and physician supervision by which medical treatment services provided by physicians and nonphysician medical practitioners are integrated and made consistent with accepted medical practice.

s 51172. Date of Service.

Notwithstanding any other Department regulation, for purposes of billing for prescribed drugs, the date of service means the date a prescription is filled. If the drug has not been received by the beneficiary or the beneficiary's representative within 15 days after the prescription is filled, the pharmacy must reverse the claim and refund the payment to the Department.

s 51173. Acute Administrative Days.

Acute administrative days means those days approved in an acute inpatient facility which provides a higher level of medical care than that currently needed by the patient.

s 51173. Acute Administrative Days.

Acute administrative days means those days approved in an acute inpatient facility which provides a higher level of medical care than that currently needed by the patient.

s 51174. Paramedic Ambulance Services.

s 51175. Nurse Midwife Services.

Nurse midwife services means services provided by nurse midwives, acting within the scope of their practice.

s 51176. Home and Community-Based Waiver Services.

(a) Home and community-based waiver services which are permitted and defined under appropriate federal waiver are those services available to individuals in order to avoid

institutionalization. Federal waivers as used in this chapter in reference to home and community-based services are embodied in the following:

(1) Waiver for service to the developmentally disabled effective October 1, 1992 and as periodically amended and/or renewed;

(2) Waiver for services to the elderly effective July 1, 1987 and as periodically amended and/or renewed;

(3) In-Home Medical Care Services Waiver, effective July 1, 1987 and as periodically amended and/or renewed;

(4) Skilled Nursing Facility Level of Care Waiver, effective July 1, 1987 and as periodically amended and/or renewed;

(5) Model Waiver, effective July 1, 1988 and as periodically amended and/or renewed;

(6) Waiver for People with AIDS and Related Conditions, effective January 1, 1989 and as periodically amended and/or renewed; and

(7) Nursing Facility Waiver Services.

(b) Home and community-based services may include the following:

(1) Case Management

(2) Home-maker

(3) Home Health Aide

(4) Personal Care

(5) Habilitation

(6) Respite Care

(7) Day Treatment

(8) Other services as determined necessary by the Department to accomplish the objectives of the program.

EDITORIAL NOTE: The approved waivers are available for review at Department of Health Services, Chief, Alternative Services Unit, Medi-Cal Benefits Branch, 714 P Street, Sacramento, CA 95814.

s 51177. Swing Bed Services.

Swing bed services are skilled nursing facility services as defined in Section 51123 which are provided by a swing bed facility.

s 51178. Swing Bed Facility.

Swing bed facility means a hospital as defined in Section 51109 which meets the standards for swing bed facility participation specified in Section 51247.

s 51179. Comprehensive Perinatal Services.

"Comprehensive perinatal services" means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.

s 51179.1. Comprehensive Perinatal Provider.

"Comprehensive perinatal provider" means any general practice physician, family practice physician, obstetrician/gynecologist, pediatrician, a group, any of whose members are one of the above-named physicians, or any preferred provider organization,

organized outpatient clinic, or any other clinic holding a valid Medi-Cal provider number, approved by the Department to provide comprehensive perinatal services.

s 51179.3. Comprehensive Perinatal Psychosocial Services.

"Comprehensive perinatal psychosocial services" means direct patient care psychosocial services provided by any qualified professional as specified in Section 51179.7, pursuant to protocols as defined in Section 51179.10.

s 51179.4. Comprehensive Perinatal Health Education Services.

"Comprehensive perinatal health education services" means direct patient care health education services provided by any qualified professional as specified in Section 51179.7, pursuant to protocols as defined in Section 51179.10.

s 51179.5. Personal Supervision.

"Personal supervision" means evaluation, in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means.

s 51179.6. Case Coordination.

"Case coordination" means organizing the provision of comprehensive perinatal services, and includes, but is not limited to, supervision of all aspects of patient care including antepartum, intrapartum, and postpartum.

s 51179.7. Comprehensive Perinatal Practitioner.

(a) "Comprehensive Perinatal Practitioner" means any one of the following:

(1) A physician who is either:

(A) A general practice physician, or

(B) A family practice physician, or

(C) A pediatrician, or

(D) An obstetrician-gynecologist.

(2) A Certified Nurse Midwife as defined in Section 51170.2.

(3) A Registered Nurse who is licensed as such by the Board of Registered Nursing and who has one year experience in the field of maternal and child health.

(4) A Nurse Practitioner as defined in Section 51170.3.

(5) A Physician's Assistant as defined in Section 51170.1.

(6) A social worker who either:

(A) Holds a Master's Degree or higher in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year of experience in the field of Maternal and Child Health, or

(B) Holds a Master's Degree in psychology or Marriage, Family and Child counseling and has one year of experience in the field of Maternal and Child Health, or

(C) Holds a Baccalaureate Degree in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year experience in the field of Maternal and Child Health.

(7) A health educator who either has:

(A) A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health, or

(B) A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of Maternal and Child Health.

(8) A childbirth educator who is:

(A) Licensed as a Registered Nurse by the Board of Registered Nursing and has one year experience in a program which complies with the "Guidelines for Childbirth Education" (last published in 1981), herein incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, South West, Suite 300 East, Washington, D.C., 20024-2588 or

(B) A Certified Childbirth Educator who has completed a training program and is currently certified to teach that method of childbirth education by the American Society for Psychoprophylaxis in Obstetrics, or Bradley, or the International Childbirth Education Association.

(9) A dietitian who is registered, or is eligible to be registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, with one year of experience in the field of perinatal nutrition.

(10) A comprehensive perinatal health worker who:

(A) Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care;

(B) Provides services in a clinic that is either licensed or exempt from licensure under Section 1200 et seq. and 1250 et seq. of the Health and Safety Code, under the direct supervision of a comprehensive perinatal practitioner as defined in Section 51179.7(a)(1).

(11) A licensed vocational nurse who is licensed under Section 2516 of the Business and Professions Code and who has one year of experience in the field of Maternal and Child Health.

s 51179.8. Individualized Care Plan.

"Individualized Care Plan" means a document developed by a comprehensive perinatal practitioner(s) in consultation with the patient. The plan consists of four components; obstetrical, nutritional, health education, and psychosocial. Each component includes identification of risk conditions, prioritization of needs, proposed interventions including methods, timeframes, and outcome objectives, proposed referrals and staff persons' respective responsibilities, based on the results of assessments.

s 51179.9. Protocol.

"Protocol" means written procedures for providing psychosocial, nutrition, and health education services and related case coordination. Protocols shall be approved by the Comprehensive Perinatal Provider as defined in Section 51179.7(a)(1) and the Comprehensive Perinatal Practitioners as defined in Sections 51179.7(a)(6)(C) or 51179.7(a)(6)(B), and Section 51179.7(a)(7)(A) and Section 51179.7(a)(9). Protocols shall be developed, approved, and adopted within six months of the effective date of provider approval as a Comprehensive Perinatal Provider.

s 51179.10. Protocol.

s 51180. Hospice Care.

(a) Hospice care means the provision of palliative and supportive items and services described below to a terminally ill individual as defined in Section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider:

(1) Nursing services;

(2) Physical or occupational therapy, or speech-language pathology;

- (3) Medical social services under the direction of a physician;
- (4) Home health aide and homemaker services;
- (5) Medical supplies and appliances;
- (6) Drugs and biologicals;
- (7) Physician services;
- (8) Short-term inpatient care;
- (9) Counseling, including bereavement, dietary and spiritual counseling;
- (10) Any other item or service for which payment may otherwise be made under the Medi-Cal program.

s 51180.1. Hospice.

(a) Hospice means a public agency or private organization, or a subdivision thereof, or a facility which:

(1) Is primarily engaged in providing the items and services described in Section 51180 to terminally ill individuals.

(2) Makes such services available as needed on a 24-hour basis, and

(3) Provides bereavement counseling for the immediate family and significant others.

s 51180.2. Terminally Ill.

Terminally ill means that an individual's medical prognosis as certified by a physician is that his or her life expectancy is six months or less.

s 51180.3. Routine Home Care.

Routine home care means care provided in the individual's residence which is not continuous care.

s 51180.4. Continuous Home Care.

Continuous home care means care provided in the individual's residence, which consists predominately of skilled nursing care, for a minimum of eight hours in a 24-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the patient's care.

s 51180.4. Continuous Home Care.

Continuous home care means care provided in the individual's residence, which consists predominately of skilled nursing care, for a minimum of eight hours in a 24-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the patient's care.

s 51180.6. General Inpatient Care.

General inpatient care means services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.

s 51180.7. Representative.

Representative means a person who, because of a terminally ill individual's mental or physical incapacity, is lawfully authorized in accordance with the procedures set forth in Civil Code Section 2500 et seq. or otherwise to execute or revoke an election for hospice care or terminate medical care on behalf of the individual.

s 51180.7. Representative.

Representative means a person who, because of a terminally ill individual's mental or physical incapacity, is lawfully authorized in accordance with the procedures set forth in Civil Code Section 2500 et seq. or otherwise to execute or revoke an election for hospice care or terminate medical care on behalf of the individual.

s 51182. Personal Representative.

For purposes of Section 51204 and 51350, "personal representative" means the duly appointed guardian or conservator of the individual or a person representing the individual provided that it can be established with reasonable certainty through forms, documents or correspondence that such person is authorized to represent the individual.

s 51183. Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal care services include:

(1) Assisting with ambulation, including walking or moving around (i.e., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming including the cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rising, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

(5) Repositioning, transfer skin care, and range of motion exercises.

(A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, sofa, and the like, coming to a standing position and/or rubbing skin and repositing to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.

(7) Assistance with self administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

(B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.

(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

(b) Ancillary services are subject to time per task guidelines when established in Sections 30-758 and 30-763.235(b) and 30-763.24 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

(2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

(4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking, and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

(6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) removal of high grass or weeds and rubbish when this constitutes a fire hazard

(B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

(c) Ancillary services may not be provided separately from personal care services listed in section (a) above.

s 51184. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Definitions.

(a) EPSDT Screening Services means:

(1) An initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17, Sections 6800 et seq.; or

(2) A health assessment, examination, or evaluation of a Medi-Cal eligible individual under 21 years of age by a licensed health care professional acting within his or her scope of practice, at intervals other than those specified in paragraph (a)(1) to determine the existence of physical or mental illnesses or conditions; or

(3) Any other encounter with a licensed health care professional that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition for a Medi-Cal eligible person under 21 years of age.

(b) EPSDT diagnosis and treatment services means only those services provided to persons under 21 years of age that:

(1) Are identified in section 1396d(r) of title 42 of the United States Code,

(2) Are available under this chapter without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal Medicaid law other than section 1396d(a)(4)(B) and section 1396a(a)(43) of title 42 of the United States Code, and

(3) Meet the standards and requirements of Sections 51003 and 51303, and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.

(c) EPSDT supplemental services means health care, diagnostic services, treatment, and other measures, that:

(1) Are identified in Section 1396d(r) of Title 42 of the United States Code.

(2) Are available only to persons under 21 years of age,

(3) Meet any one of the standards of medical necessity as set forth in paragraphs (1), (2), or (3) of Section 51340(e), and

(4) Are not EPSDT diagnosis and treatment services.

(d) EPSDT supplemental services include EPSDT case management services when provided by EPSDT case managers described in paragraph (h)(4).

(e) EPSDT diagnosis and treatment provider means any of the providers listed under Section 51051, other than EPSDT supplemental services providers.

(f) EPSDT Supplemental Services Provider means a person enrolled pursuant to Section 51242 to provide EPSDT supplemental services as defined in subsection (c).

(g) EPSDT case management services means services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services.

(h) EPSDT case manager means:

(1) A targeted case management (TCM) provider under contract with a local governmental agency described in Section 14132.44 of the Welfare and Institutions Code.

(2) Entities and organizations, including Regional Centers, that provide TCM services to persons described in Section 14132.48 of the Welfare and Institutions Code.

(3) A unit within the Department designated by the Director.

(4) A child protection agency, other agency or entity serving children, or an individual provider, that the Department finds qualified by education, training, or experience, and that the Department enrolls pursuant to Section 51242 to provide EPSDT case management services.

(i) For purposes of the EPSDT program, excepting pediatric day health care EPSDT services provided as EPSDT supplemental services, the term "services" is deemed to include supplies, items, or equipment.

(j) EPSDT supplemental services include pediatric day health care EPSDT services when provided by a pediatric day health care facility.

(k) For purposes of pediatric day health care EPSDT services, the following definitions shall apply:

(1) "Pediatric day health care EPSDT services" means services that:

(A) Promote the physical, developmental and psychosocial well-being of individuals eligible for EPSDT services who are medically fragile as defined in Section 1760.2(b) of the Health and Safety Code and who live with their parent, foster parent, or legal guardian.

(B) Provide medically necessary skilled nursing care and therapeutic interventions which include occupational therapy, physical therapy, speech therapy and medical nutrition therapy provided by licensed or registered therapists and furnished in response to the attending physician's orders and in accordance with the individual's plan of treatment. These services do not include respite care pursuant to Section 14132.10(a), of the Welfare and Institutions Code.

(C) Are provided in a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning and social interaction designed to optimize the individual's medical status and developmental functioning so that he or she can remain within the family.

(2) "Pediatric day health care facility" means a facility that is licensed pursuant to Section 1760 of the Health and Safety Code. For purposes of providing pediatric day health care EPSDT services, a pediatric day health care facility may also be referred to as the "facility".

(3) "Pharmaceutical services" means medications, including prescription and nonprescription, and total parental nutrition supplied to eligible beneficiaries by licensed nursing personnel and administered upon orders of the attending physician.

(4) "Nutrition services" means a minimum of one meal per day, between meal nourishment, and consultation services by the facility's dietitian.

s 51185. Targeted Case Management Services Program Definitions.

(a) "Encounter" means a face-to-face contact or a significant telephone contact in lieu of a face-to-face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more targeted case management service components by a case manager. For the target populations specified in Section 50262.7(a)(3)(B), (C) or (D), the encounter may be with persons acting on behalf of the Medi-Cal beneficiary.

(b) "High-risk persons" means those persons who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence, including, but not limited to, the following individuals:

(1) Women, infants, children and young adults to age 21.

(2) Pregnant women.

(3) Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome.

(4) Persons with reportable communicable disease.

(5) Persons who are technology dependent. Solely for the purposes of the Targeted Case Management Services program, "technology dependent persons" means those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.

(6) Persons with multiple diagnoses who require services from multiple health/social service providers.

(7) Persons who are medically fragile. Solely for the purposes of the Targeted Case Management Services program, "medically fragile persons" means those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

(c) "Host county" means the local governmental agency that has been designated by all local governmental agencies participating in the targeted case management program, to be the administrative and fiscal intermediary between the department and all participating local governmental agencies.

(d) "Local Governmental Agency" means a county or chartered city.

(e) "Skilled Professional Medical Personnel" means a physician, dentist, or nurse, or other specialized personnel who has completed a 2-year or longer program leading to an academic degree or certification in a medically-related profession and who performs duties and responsibilities requiring professional medical knowledge and skills, and who is in an employer-employee relationship with the local governmental agency.

(f) "Year", "current year" or "fiscal year" means the period July 1 through June 30.

s 51187. Tuberculosis (TB) Infection.

(a) Tuberculosis (TB) Infection means a condition in which living tubercle bacilli are present in an individual with or without producing active disease.

(b) For the purposes of this program, an individual is considered TB infected if a physician indicates a positive diagnosis or a suspicion of TB infection in his/her diagnosis. A TB infected individual includes, but is not limited to, an individual who:

(1) Has a positive Tuberculin skin test using the Mantoux method and who receives treatment for latent TB infection or active TB;

(2) Has a negative Tuberculin skin test but whose sputum culture or culture from another tissue sample is positive for the Tuberculosis organism;

(3) Has never received a Tuberculin skin test but whose sputum culture or culture from another tissue sample is positive for the Tuberculosis organism;

(4) Has a negative Tuberculin skin test and whose sputum or other tissue culture for TB is not or cannot be obtained, but in the physician's judgement he/she requires and is given TB-related drug and/or surgical therapy;

(5) Is symptomatic with a negative TB skin test who is being treated with a TB drug regimen while awaiting the TB culture results because the physician suspects he/she may have active TB, until such time as the individual's culture turns out to be negative for TB, causing the TB drug regimen to be discontinued.

s 51187.1. Tuberculosis (TB) Related Services.

(a) Tuberculosis (TB) Related Services for persons eligible for the TB program pursuant to Section 50268 means outpatient medical services related to the diagnosis and treatment of TB infection.

(1) TB diagnostic services means those outpatient services necessary to confirm the presence of TB infection or active disease.

(2) TB related treatment means all outpatient services necessary for the medical management and follow-up of TB infection and/or active disease, which may include drug therapy, Targeted Case Management pursuant to the requirements of Section 14132.44, Welfare and Institutions Code and directly observed therapy (DOT) when provided by a provider listed under Section 51051, who meets the qualifications specified

in Section 51276. DOT means the direct observation of the ingestion of prescribed anti-tuberculosis medications by TB infected persons. DOT includes:

- (A) Delivering of prescribed medications;
- (B) Assisting with the means to ingest prescribed medications;
- (C) Observing the ingestion of prescribed medications;
- (D) Monitoring for signs of nonadherence or adverse side effects;
- (E) Documenting that prescribed medications have been ingested; and
- (F) Reporting compliance and/or other problems.

s 51190.1. Local Educational Agency (LEA) Eligible Beneficiary.

For the purposes of this article, a "Local Educational Agency (LEA) eligible beneficiary" means a person eligible for services under Title XIX of the Social Security Act and certified for Medi-Cal who is one of the following:

- (a) Under age 22 and enrolled in a school within an LEA in California. Any person who becomes 22 years of age while participating in an Individualized Education Plan or Individualized Family Service Plan may continue his or her participation in the program for the remainder of that current school year; or
- (b) A Medi-Cal eligible family member of a student meeting subsection (a) above.

s 51190.1. Local Educational Agency (LEA) Eligible Beneficiary.

For the purposes of this article, a "Local Educational Agency (LEA) eligible beneficiary" means a person eligible for services under Title XIX of the Social Security Act and certified for Medi-Cal who is one of the following:

- (a) Under age 22 and enrolled in a school within an LEA in California. Any person who becomes 22 years of age while participating in an Individualized Education Plan or Individualized Family Service Plan may continue his or her participation in the program for the remainder of that current school year; or

(b) A Medi-Cal eligible family member of a student meeting subsection (a) above.

s 51190.3. Local Educational Agency (LEA) Practitioner.

(a) A "Local Educational Agency (LEA) Practitioner" means an employee or individual under contract to an LEA Provider to furnish LEA Services to LEA eligible beneficiaries. All LEA practitioners except the practitioner identified in (21) below shall provide documented evidence of being licensed, certified, registered, or otherwise credentialed to practice in California as one of the following:

- (1) A licensed physician,
- (2) A licensed registered nurse, including a registered credentialed school nurse or a certified public health nurse,
- (3) A certified nurse practitioner,
- (4) A licensed vocational nurse,
- (5) A licensed clinical social worker,
- (6) A registered dietician,
- (7) A licensed physician's assistant,
- (8) A licensed psychologist,
- (9) A licensed marriage, family and child counselor,
- (10) A licensed optometrist,
- (11) A licensed speech therapist,

- (12) A licensed audiologist,
- (13) A credentialed school psychologist,
- (14) A credentialed school social worker,
- (15) A credentialed school counselor,
- (16) A registered school audiometrist,
- (17) A credentialed language, speech and hearing specialist,
- (18) A licensed physical therapist,
- (19) A registered occupational therapist,
- (20) A licensed psychiatrist, or
- (21) A trained health care aide as specified in Section 51491(g)(1).

(b) Any person who is suspended from participation in the Medi-Cal program may not furnish services as an LEA Practitioner.

(c) An LEA practitioner shall provide services only within his/her appropriate scope of practice.

s 51190.4. Local Educational Agency (LEA) Services.

"Local Educational Agency (LEA) Services" means preventive, diagnostic, therapeutic, and rehabilitative services that are:

- (a) Listed in Section 51360;

(b) Medically necessary as defined in Welfare and Institutions Code, Section 14059.5;

(c) Provided on an outpatient basis; and

(d) Provided to an LEA eligible beneficiary, as defined in Section 51190.1; by an LEA practitioner, as defined in Section 51190.3; on or after January 1, 1993.

s 51190.5. Managed Care Plan.

"Managed Care Plan" means an entity contracting with the Department to provide health care services to enrolled Medi-Cal beneficiaries under Chapter 7, commencing with Section 14000 or Chapter 8, commencing with Section 14200 of Division 9, Part 3 of the Welfare and Institutions Code.

s 51191. Licensed Midwife.

"Licensed Midwife" means an individual who holds a current, unrevoked, unsuspended license to practice midwifery under the Licensed Midwifery Practice Act of 1993, as set forth in Business and Professions Code Section 2505, et seq., and the regulations adopted thereunder.

s 51192. Licensed Midwife Services.

Licensed midwife services means services rendered by a licensed midwife, which are performed in accordance with Section 2507 of the Business and Professions Code, and Section 51356 of this Chapter.

s 51200. Basic Requirement for Program Participation.

(a) In addition to any other statutory or regulatory conditions for participation in the Medi-Cal program and any federal requirements for participation in Medicaid, as a condition for enrollment, or continued enrollment, an applicant or provider also shall meet the standards specified in this Article, applicable to their provider type, and the requirements specified in Sections 51000.30 through 51000.55. Failure to meet applicable standards for participation shall result in the denial of the applicant's or provider's application for enrollment, or continued enrollment, as specified in Section 51000.50.

(b) Any provider who violates any provision of law or regulation that governs the Medi-Cal program shall be subject to temporary or permanent suspension from the Medi-Cal program, as permitted by Section 14123, Welfare and Institutions (W&I) Code.

(c) All providers shall be subject to temporary suspension, including temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program, under any of the following circumstances:

(1) The provider has failed to disclose all information required in federal Medicaid regulations or any other information required by the Department, or has disclosed false information, as specified in Section 14043.2, W&I Code.

(2) The provider is discovered to be under investigation for fraud or abuse, as specified in Section 14043.36.

(3) The provider has failed to remediate discrepancies that are discovered as a result of an unannounced visit to the provider, as specified in Section 14043.7, W&I Code.

(d) All applicants applying for enrollment, or providers applying for continued enrollment, in the Medi-Cal program shall be certified for participation in the Medicare program of the Federal Social Security Act (Title XVIII), if they provide services that are included in the Medicare scope of benefits and if they provide those services to persons who are eligible beneficiaries of the Medicare program.

(e) Any provider who requests the performance of a clinical laboratory test or examination for a Medi-Cal beneficiary, or upon a biological specimen derived from a Medi-Cal beneficiary, shall provide with the request to the clinical laboratory diagnostic information relevant to the test or examination for which the request is made, including the latest International Classification of Diseases, 9th Revision, or the latest published editions or amendments thereto, Clinical Modification (ICD-9-CM) code numbers, to the highest level of specificity indicating medical necessity for all laboratory tests as required under the Medicare program pursuant to 42, U.S.C., Section 1395u(p) and 42, CFR, Section 424.32.

(f) In addition to meeting and complying with all applicable requirements specified in Articles 1, 2, and 3, any place where a provider, as defined in Section 51051(a), renders laboratory or clinical laboratory services as defined in Section 51137.2 and any person performing, supervising, consulting on, or directing such laboratory or clinical laboratory services shall meet and maintain compliance with the requirements of Section 51211.2.

s 51200.01. Established Place of Business.

s 51201. Physical Therapy.

s 51201.1. Physical Therapist.

A physical therapist shall be licensed as a Registered Physical Therapist by the California Board of Medical Quality Assurance, or similarly registered or licensed by a comparable agency in the state in which the therapist practices, and shall be a graduate of a program in physical therapy approved by the agency or organization recognized by the Council on Post Secondary Accreditation or the U.S. Department of Education, or its equivalent. Physical therapists certified by the Physical Therapy Examining Committee may perform tissue penetration for the purpose of evaluating neuromuscular performance.

s 51202. Speech Pathologist.

A speech therapist shall be licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which he practices.

s 51202.5. Sign Language Interpreters.

(a) Individuals who provide sign language interpreter services shall possess the ability to communicate effectively, accurately and impartially both receptively and expressively in a medical setting, and either;

(1) Hold a current certification by one of the following:

(A) The National Registry of Interpreters for the Deaf (RID);

(B) The National Association of the Deaf (NAD)/California Association of the Deaf (CAD) at a competency Level IV or V only; or

(C) The California Department of Rehabilitation at a competency Level III and posses a certificate from RID, NAD/CAD at a competency Level IV or V only; or

(2) Be non-certified.

(b) An individual who provides sign language interpreter services shall not be related to the beneficiary by heredity or by marriage, or live in the same household.

(c) A beneficiary may select an individual to provide sign language interpreter services, except those persons excluded in (b). However, in an emergency or acute care situation or in the event the provider determines the interpreter does not communicate effectively, accurately or impartially, the physician may override the beneficiary's selection and select the interpreter.

s 51203. Occupational Therapy.

s 51203.1. Occupational Therapist.

An occupational therapist shall be a graduate of a curriculum in occupational therapy approved by the Council on Education of the American Medical Association in collaboration with the American Occupational Therapy Association, and shall be registered by the American Occupational Therapy Association.

s 51204. Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426(1/93)] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care services. Beneficiaries shall be given a choice of service provider.

(a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.

(b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

s 51205. Prosthetic and Orthotic Appliance Facilities.

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s 51206. Hospitals, Home Health Agencies and Laboratories.

s 51206. Hospitals, Home Health Agencies and Laboratories.

s 51208. Dispensing Optician.

A dispensing optician shall have a permit as a registered dispensing optician issued by the California Board of Medical Quality Assurance or shall hold a permit issued by a comparable agency in the state in which he practices.

s 51208.1. Fabricating Optical Laboratory.

A fabricating optical laboratory, as defined in Section 51162.1, shall meet all of the following conditions:

(a) Be licensed by the Department as a device manufacturer, in accordance with Section 10376, Title 17, California Code of Regulations; and

(b) Meet the quality standards for prescription ophthalmic appliances as specified in the American National Standards Institute (ANSI) Standard Z80.1, copyright 1972, published by the American National Standards Institute, 1430 Broadway, New York, NY 10018; and

(c) Enter into an exclusive area negotiated contract for ophthalmic appliances with the Department of Health Services.

s 51209. Hospital Outpatient Department.

A hospital outpatient department shall be operated by a hospital certified for participation in the Medi-Cal Program and shall be staffed by personnel who meet the standards of Division 3, Chapter 3, Article 3 of Title 22, California Administrative Code when providing services outlined in Section 51331.

s 51209. Hospital Outpatient Department.

A hospital outpatient department shall be operated by a hospital certified for participation in the Medi-Cal Program and shall be staffed by personnel who meet the standards of Division 3, Chapter 3, Article 3 of Title 22, California Administrative Code when providing services outlined in Section 51331.

s 51211. Other Organized Outpatient Services.

s 51211.1. Organized Outpatient Clinic.

An organized outpatient clinic shall be a clinic, or an establishment for handicapped persons, which is so licensed by and which meets the standards for such licensure of the Department, or is similarly licensed by a comparable agency in the state in which it is located, or is exempt from licensure under the provisions of Section 1206 or Section 1505 of the California Health and Safety Code.

(a) In any organized outpatient clinic which provides physical therapy services, there shall be at least one physical therapist who meets the standards of Section 51201.1, and such other properly trained and supervised physical therapy personnel as are necessary to meet the needs of the organized outpatient clinic.

(b) In any organized outpatient clinic which provides occupational therapy services, there shall be at least one registered occupational therapist who meets the standards of Section 51203.1 and such other properly trained and supervised occupational therapy personnel as are necessary to meet the needs of the organized outpatient clinic.

s 51211.2. Laboratory or Clinical Laboratory.

(a) A laboratory or clinical laboratory in California or receiving biological specimens (as defined in Business and Professions Code section 1206) originating in California shall:

(1) Be operated under a current, unrevoked and unsuspended clinical laboratory license or registration issued by the department pursuant to division 2, chapter 3, (commencing with section 1200) of the Business and Professions Code; or a current, unrevoked and unsuspended certificate of approval issued by the department pursuant to sections 1000-1003 inclusive of the Health and Safety Code; or be exempt from licensure and registration under Business and Professions Code section 1241 or 1244; and

(2) Have a current, unrevoked and unsuspended, certificate appropriate for the type and complexity of clinical laboratory tests or examinations performed, issued pursuant to the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988, 42 United States Code section 263a; P.L. 100-578 and its implementing regulations, 42, Code of Federal Regulations part 493. If the United States Department of Health and Human Services (HHS) exempts clinical laboratories, laboratories or public health laboratories licensed, registered or otherwise approved by the department from the requirements of CLIA pursuant to (p) of section 263a of title 42 of the United States Code and section 493.513 of title 42 of the Code of Federal Regulations, this subsection's requirements regarding a CLIA certificate shall not apply, but only to those clinical laboratories, laboratories or public health laboratories exempted by HHS and only for the period of such exemption.

(3) If providing services to persons who are Medicare eligible, be certified or meet the requirements for certification under title XVIII of the Federal Social Security Act, and have elected to provide services under title XVIII, or

(4) If providing services to persons who are not Medicare eligible, be certified or meet the requirements for certification under title XVIII of the Federal Social Security Act.

(b) All persons performing, supervising, consulting on, or directing laboratory or clinical laboratory services in California or on biological specimens originating in California shall comply with the requirements set forth in division 2, chapter 3 (commencing with section 1200) of the Business and Professions Code and the regulations adopted thereunder for the type and complexity of testing performed.

(c) For the purposes of providing laboratory services for qualified practitioners whose practices are conducted solely in states other than California and on biological specimens that do not originate in California, a laboratory or clinical laboratory shall be certified to provide services under the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988, 42 United States Code section 263a; P.L. 100-578 and shall be licensed, registered or otherwise approved by the appropriate state agency in the state in which it is located, if such licensure, registration or approval is required.

s 51211.5. Rural Health Clinic Standards for Participation.

(a) Each rural health clinic shall:

(1) Be licensed or exempt from licensure under Chapter 1, Division 2, California Health and Safety Code.

(2) Be located in a rural shortage area at the time of initial certification or be a private, nonprofit facility that meets all other conditions except for location in a shortage area and was operating in a rural area on July 1, 1977 that was subsequently determined by the Secretary, Department of Health and Human Services, to have an insufficient supply of physicians to meet the needs of the area served.

(3) Be certified and continue to meet the standards for certification as a rural health clinic established by the Secretary, Department of Health and Human Services.

(4) Provide that a physician or nonphysician medical practitioner be available to furnish patient care services at all hours of clinic operation. A nonphysician medical practitioner shall be available to furnish patient care services at least 60 percent of the hours of clinic operation.

(5) Execute a provider participation agreement with the Director containing, but not limited to, the following provisions:

(A) The participation agreement shall be subject to the same terms and conditions, and be coterminous with the period of eligibility, specified by the Secretary, Department of Health and Human Services.

(B) The participation agreement, including that of a provider who voluntarily withdraws from participation in Medicare, shall continue to be valid only if the provider continues to be certified as meeting the standards as a rural health clinic established by the Secretary, Department of Health and Human Services.

(C) The provider may terminate the participation agreement by filing a written notice with the Director stating the effective date of termination. The Director may approve:

1. The date selected by the clinic.
2. A date that is six months after the date on which the clinic filed notice.
3. A date that is less than six months after the date on which the clinic filed notice if the Director determines that termination on that date would not unduly disrupt service to the community served or interfere with the administration of the Medi-Cal program.

(D) A clinic that ceases to furnish services to the community shall be deemed to have voluntarily terminated the participation agreement, effective on the last day of service.

(6) Maintain any records and accounts required by the Director in accordance with State and Federal law.

(b) The Department shall take appropriate action to deny or terminate the rural health clinic's participation under Medi-Cal upon notification that a provider participation agreement with a facility under Title XVIII of the Act has been terminated.

(c) A clinic whose agreement has been cancelled or otherwise terminated by the Department shall not be issued another provider participation agreement until the reasons which caused the cancellation or termination have been removed and a reasonable assurance provided the survey agency that they will not recur.

s 51212. Intermediate Care Facility.

(a) An intermediate care facility as defined in section 51118 shall:

(1) Be licensed by the Department of Health Services as an intermediate care facility unless exempt under state law from licensure. (Facilities which are licensed by the Department of Health services as a hospital or skilled nursing facility may also provide intermediate care services if they meet all the requirements of this section.)

(2) Be certified to participate in the Medi-Cal program as a provider of intermediate care services and execute a provider participation agreement with the Department, and be in compliance with the requirements contained in title XIX of the Social Security Act and regulations promulgated pursuant thereto. The certification notice shall be conspicuously posted in the facility on a public bulletin board in the area open to and usually frequented by patients, physicians, and visitors.

(3) Assure that Medi-Cal beneficiaries in the facility are visited by their attending physicians in accordance with section 51334(f) of this chapter.

(4) Grant access to Medi-Cal beneficiaries and their records to authorized personnel of the Department.

(b) Notwithstanding any other provisions of these regulations, those sanatoria or skilled nursing facilities operated by, or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, shall be eligible for participation in this program as an intermediate care facility provided they conform with the requirements of the local governmental authorities in the areas in which they are located with regard to housing, fire protection, safety, and sanitation.

(c) Facilities shall notify the Medi-Cal consultant's office within 48 hours of all discharges or deaths of Medi-Cal beneficiaries in their facilities.

s 51213. Rehabilitation Center.

(a) A rehabilitation center shall be certified by the Department as meeting the requirements of this section, shall be approved by the Department and shall meet the requirements of either (b) or (c) and all the other provisions of this section.

(b) Such rehabilitation center shall be a hospital, which meets the standards for participation set forth in Section 51207 and which is currently participating in the program and which was an organized outpatient department, and which

(1) Has an organized rehabilitation service, and

(2) Has as chief of the rehabilitation service a physician who has the necessary training and experience to assure proper patient assessment and care.

(c) If it is not a hospital which meets the requirements of (b) above, the rehabilitation center shall be an organized outpatient clinic. Each such rehabilitation center shall have an organized rehabilitation service and shall provide sufficient professional supervision to assure that the extended treatment plan of the attending physician will be properly carried out.

(d) The rehabilitation center shall provide two or more of the following services:

(1) Physical therapy

(2) Occupational therapy

(3) Speech therapy

(4) Audiology

(e) The rehabilitation center shall meet the standards set forth in Section 51209 or 51211.1 when providing physical therapy and occupational therapy, and employ personnel who meet the definitions set forth in Section 51079 when providing physical therapy, Section 51083 when providing occupational therapy, Section 51095 when providing speech therapy and Section 51097 when providing audiology services.

(f) The rehabilitation center shall establish and maintain a record of diagnosis, condition, treatment plan, services provided, and functional results on each patient treated. Such medical records shall include the following:

(1) The extended treatment plan required pursuant to the provisions of Section 51314 (a).

(2) Patient identification, including Social Security number.

- (3) A medical history, including a recent physical examination.
 - (4) Attending physician's orders.
 - (5) A complete record of all services rendered by the rehabilitation center.
 - (6) Progress notes.
 - (7) Copies of laboratory and radiology reports as they relate to conditions treated by the rehabilitation center.
 - (8) Medication records.
- (g) Each such rehabilitation center shall have written policies that provide for:
- (1) Arrangements with Medi-Cal providers to provide laboratory, x-ray, and other ancillary services on an as needed basis.
 - (2) A utilization review plan that includes:
 - (A) The organization and composition of a utilization review committee, which shall include at least one physician and which shall be responsible for the utilization review functions.
 - (B) The frequency of meetings which shall be not less than monthly.
 - (C) A selection of cases for review on a random sample basis of not less than one case in every ten.
 - (D) A summary of the number and types of cases reviewed, and the findings on each.

(E) The actions to be taken by the rehabilitation center based on the findings and recommendations of the utilization review committee.

(3) Notification of the utilization review committee of all new patients for whom the rehabilitation center assumes responsibility for treatment. The utilization review committee shall also be provided with a monthly updated list of all rehabilitation center patients.

(4) The medical records of each patient to be available from the rehabilitation center for the use of the utilization review committee.

(5) The names and office or facility locations of consultants who are available to provide consultation on an individual case basis to the rehabilitation center, on request, for those professional services provided by the rehabilitation center.

s 51214. Hearing Aid Dispenser.

A Hearing Aid Dispenser shall be licensed as a hearing aid dispenser by the California Board of Medical Quality Assurance.

s 51215. Skilled Nursing Facilities.

(a) A skilled nursing facility, as defined in section 51121, shall:

(1) Be licensed by the Department of Health Services unless exempt under state laws from licensure. (facilities which are licensed by the Department of Health Services as hospitals may also provide skilled nursing facility services if they meet all of the requirements of this section.

(2) Be certified to participate in the Medi-Cal program as a provider of skilled nursing facility services by being in compliance with the Medicare and Medicaid requirements of Titles XVIII and XIX of the Social Security Act and regulations promulgated pursuant thereto.

(3) Execute a provider participation agreement with the Department of Health Services for participation in the Medi-Cal program. Facilities participating in both the Medicare and Medicaid programs shall be subject to the same terms and conditions, and be coterminous with the period of approval of eligibility, specified by the United States Department of Health and Human Services pursuant to title XVIII of the Social Security Act. Upon notification that a provider participation agreement with a facility under title XVIII of the Act has been terminated, the Department may take appropriate action to deny or terminate the facility's participation under Medi-Cal. A facility whose agreement under title XVIII has been canceled or otherwise terminated shall not be issued another provider participation agreement until the reasons which caused the cancellation or termination have been removed and a reasonable assurance provided the survey agency that they will not recur.

(4) Assure that Medi-Cal beneficiaries in the facility are visited by their attending physicians in accordance with section 51335 (f) of this chapter.

(5) Notify the Medi-Cal consultant's office within 48 hours of all discharges and deaths of Medi-Cal beneficiaries in that facility .

(b) Notwithstanding the provisions of subsection (a) of this regulation, eligibility for participation in the program shall be conditional on compliance with Welfare and Institutions Code section 14105.5.

(c) Notwithstanding any other provisions of these regulations, those sanitariums or skilled nursing facilities operated by, or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, shall be eligible for participation in this program, provided they conform to housing, fire protection, safety and sanitation requirements of the local communities where they are located. Execute a provider participation agreement with the Department of Health Services for participation in the Medi-Cal program.
Facilities

s 51215.4. Transitional Inpatient Care Unit.

s 51215.5. Subacute Care Unit.

(a) A subacute care unit means an identifiable unit of a skilled nursing facility accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the Department for such purpose.

(b) In addition to the requirements set forth in subsections (c) through (l) a subacute care unit shall comply with all of the licensing and certification requirements set forth in Title 22, Division 5, otherwise applicable to a skilled nursing facility.

(c) The facility shall accept and retain only those subacute patients for whom it can provide adequate care.

(d) Subacute beds shall not be dual classified as swing beds as they are defined in Section 1339.5 of the Health and Safety Code.

(e) Subacute care units shall employ sufficient nursing staff as follows: freestanding SNFs shall provide a minimum daily average of 3.8 actual licensed nursing hours per patient day and 2.0 actual certified nurse assistant (CNA) hours per patient day; distinct part SNF's shall provide a minimum daily average of 4.0 actual licensed nursing hours per patient day and 2.0 actual CNA hours per patient day. Subacute units that do not utilize CNAs shall employ sufficient licensed nursing staff to provide 4.8 actual licensed nursing hours per patient day.

(f) In providing for the licensed nursing hours requirement in accordance with subsection (e) above, each subacute care unit shall have a minimum of one registered nurse (RN) per shift.

(g) Each RN and LVN shall upon hire provide to the employer evidence of the following: (1) A minimum of six months experience within the past two years working in a general acute care facility; or (2) An acquired equivalent competency appropriate to the type of subacute patient the facility provides care for.

(h) Nursing staff assigned to the subacute care unit shall not be assigned other duties outside of the subacute care unit during any given shift.

(i) The facility shall provide documentation upon request by the Department that the Director of Nursing, and all subacute care staff are participating in an ongoing educational program in accordance with Title 22, California Code of Regulations, Division 5, Section 70213(c), focused on subacute care.

(j) Physician services shall be provided in a subacute care unit in accordance with Title 22, California Code of Regulations, Division 5, Section 72303, with the exception of (b)(1).

(k) The attending physician shall perform an initial evaluation and prepare a written report of physical examination of the patient within 48 hours of admission to the subacute care unit.

(l) The subacute care unit shall provide the required services in accordance with Title 22, California Code of Regulations, Division 5, Section 72301(d).

s 51215.6. Participation Requirements for the Adult Subacute Program and Pediatric Subacute Program.

(a) Adult subacute services and pediatric subacute services shall be provided by a licensed general acute care hospital with distinct-part skilled nursing beds or a freestanding certified nursing facility that enters into a contract with the Department.

(b) Each applicant for an initial contract, contract amendment, or contract renewal to provide adult subacute services or pediatric subacute services, shall submit a completed application, or written request in the case of contract amendment, to the Department containing, but not limited to, evidence of the following:

(1) Licensure as a general acute care hospital with or without distinct-part skilled nursing beds, a skilled nursing facility or a Congregate Living Health Facility;

(2) Certification as a Medicare and Medi-Cal provider;

(3) History as a licensed health care facility for a period of 12 months prior to and during the initial application process, contract amendment, or contract renewal as follows:

(A) Maintenance of an uninterrupted Medi-Cal provider agreement; and

(B) As applicable to the type of facility, all deficiencies in patient care, or deficiencies of a severity which would impose immediate jeopardy or actual harm to a resident's/patient's health or safety during a facility certification survey, complaint survey or special incident investigation. The Department may terminate a contract, impose contract penalties, or deny the award of a contract, a contract amendment, or contract renewal in other instances of deficiencies found during a facility certification survey, complaint survey or special incident investigation that would not impose immediate jeopardy or actual harm to a resident's/patient's health or safety, but are determined to be widespread. These deficiencies are determined by the Department or the Center for Medicare and Medicaid Services, and

(C) As applicable to the type of facility, all citations as defined by Health and Safety Code Sections 1424(c), (d) and (e) that pertain to patient care. The presence of a citation or citations shall not, in itself, constitute the basis for denial of the contract application, amendment or renewal. A citation or citations shall be evaluated for impact

on such areas as patient care, patient safety, fraud and for indications of a pattern of noncompliance.

(4) As applicable to the type of facility, documentation that the applicant can comply with one or more of the following:

(A) With Section 51215.5 for adult subacute services;

(B) With Section 51215.8 for pediatric subacute services.

(5) An applicant for an adult subacute or pediatric subacute contract shall, in addition to the requirements of (b) of this section, provide evidence that the location of the proposed subacute unit has a subacute population and a need for subacute services. This evidence shall include a list of potential patients, with each patient's Medi-Cal identification number, current level of care, and the address of each patient's current location. The requirements of this subsection shall also apply to adult subacute and pediatric subacute contract amendments and renewals.

(6) An applicant for an adult subacute or pediatric subacute contract that is a general acute care hospital with distinct-part skilled nursing beds shall, in addition to the requirements of (b)(3) of this section, have a history of maintaining the appropriate accreditation for participation in the Medicare and Medi-Cal programs, and maintaining supplemental authorization by Licensing and Certification for a distinct-part which functions as a skilled nursing facility service. The requirements of this subsection shall also apply to adult subacute and pediatric subacute contract amendments and renewals.

(7) Nothing in this section shall preclude a new licensee without a history of providing care in a licensed health care facility from being eligible to enter into a contract with the Department to provide subacute care services to adult or pediatric patients if all other applicable requirements of the subacute care program are met.

(c) Freestanding certified nursing facilities shall specify in their application that the location of the proposed unit is within close proximity to a general acute care hospital with which the freestanding certified nursing facility has a transfer agreement and with which the physicians who assume responsibility for treatment management of patients receiving transitional inpatient care services have staff privileges.

(d) The Department shall not be precluded from imposing one or more penalties specified in subsections (1) through (5) below upon a contractor under the provisions of this section as an interim alternative to contract termination. Such action shall apply to a contractor that fails to comply with any term or condition of the initial, amended, or renewed contract and any applicable laws and regulations. Penalties may include, but are not limited to:

- (1) Suspension of new admissions;
- (2) Relocation of selected patients;
- (3) Transfer of selected patients;
- (4) Reduction in the number of beds under contract;
- (5) Reduction in the term of the contract.

(e) A contract entered into under the provisions of this section shall be renewed by the Department unless the Department determines good cause is shown for nonrenewal. Good cause shall include, but not be limited to the following:

(1) Failure of the contractor to comply with the terms and conditions of the initial contract and applicable laws and regulations;

(2) Failure of the contractor to comply with the provisions of an amended or renewed contract and applicable laws and regulations;

(3) The Department's determination, based upon the contractor's past performance under its contract, that the Contractor does not have the ability to fulfill the terms of a renewed contract with the State. The Contractor's remediation of a single or multiple areas of noncompliance shall not be construed as relief from contract nonrenewal.

(f) Contract nonrenewal shall commence following 30 calendar days' written notice of nonrenewal by the Department to the contractor. The contractor shall be responsible for the appropriate and safe disposition of affected patients. Reimbursement to the contractor

for services provided to all affected patients shall continue, unless the contractor fails to actively pursue appropriate, alternative placement for the patients.

(g) A contract entered into under the provisions of this section shall be terminated by the Department at any time during the contract term when the Department has determined good cause exists, as established in (e) of this section.

(1) The Department shall give 30 calendar days' written notice to the contractor prior to the termination of a contract.

(2) The contract shall be terminated immediately if the Department determines that there is an immediate threat to the health and safety of Medi-Cal beneficiaries.

(3) Upon notice of contract termination, the contractor shall be responsible for the appropriate and safe disposition of affected patients. Reimbursement to the contractor for services provided to all affected patients shall continue, unless the contractor fails to actively pursue appropriate, alternative placement for the patients.

(h) The provider, with 120 calendar days' written notice to the Department, may cancel an adult or pediatric subacute contract with the Department.

(i) Upon the receipt of an application to provide adult subacute care, or pediatric subacute care, the Department shall:

(1) Within 30 calendar days from receipt of the application, inform the applicant in writing whether the application is complete and acceptable or that the application is deficient and what specific information or clarification is necessary.

(2) Within 90 calendar days from receipt of a complete application, approve or deny the application.

(3) Within 60 calendar days from receipt of any information or clarification necessary to make an application complete, reach a decision to approve or deny the application for participation in the adult subacute program or pediatric subacute program.

(4) Within the 90 calendar days after an application is initially received, conduct an onsite review of the facility.

(5) Upon approval for participation in the adult subacute program or pediatric subacute care program, send a contract to the applicant.

(j) If an application for an initial contract, a contract amendment, or a contract renewal, for the adult subacute program, or pediatric subacute program is denied, the applicant has 30 calendar days from the date of the receipt of written notification of the denial to submit a written appeal to the Department. This written appeal shall contain factual statements as to why the applicant meets the criteria which have been cited as the basis for the denial of the application. The Department shall issue a written decision within 60 calendar days of receipt of the applicant's appeal.

(k) A separate and distinct cost center shall be established and maintained in order to identify and segregate costs for adult and/or pediatric subacute patients separately from costs for other patients who may be served within the certified nursing facility.

(1) Cost reporting for the adult subacute or pediatric subacute unit in freestanding certified nursing facilities shall be maintained according to generally accepted accounting principles and the uniform accounting system adopted by the State and specified in the Accounting and Reporting Manual for California Long-Term Care Facilities, pursuant to Section 97019, and shall be submitted in the manner approved by the State specified in the Accounting and Reporting Manual for California Long-Term Care Facilities, pursuant to Section 97019.

(2) Cost reporting for the adult subacute or pediatric subacute unit in distinct part skilled nursing units in general acute care hospitals shall be maintained according to generally accepted accounting principles and the uniform accounting system adopted by the State and specified in the Accounting and Reporting Manual for California Hospitals, pursuant to Section 97018, and shall be submitted in the manner approved by the State specified in the Accounting and Reporting Manual for California Hospitals, pursuant to Section 97019.

s 51215.7. Application for Subacute Care Contract.

s 51215.8. Pediatric Subacute Care Unit.

(a) A pediatric subacute care unit means an identifiable unit of a certified nursing facility licensed as a skilled nursing facility and meeting the standards for participation as a provider under the Medi-Cal program set forth in this section, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the Department for such purpose. In addition to the requirements set forth in this section, a facility providing pediatric subacute care unit services shall comply with all of the licensing requirements set forth in Title 22, Division 5, otherwise applicable to licensure as a skilled nursing facility.

(b) To the highest practicable extent, the pediatric subacute unit shall provide a safe, clean, comfortable and nurturing home-like environment designed to promote normal child development.

(c) Pediatric subacute beds shall not be dual classified as swing beds as they are defined in Section 1339.5, Health and Safety Code.

(d) The facility shall accept and retain only those pediatric subacute patients for whom it can provide appropriate care in accordance with this section, and as defined in Section 51124.6(c)(1).

(e) The pediatric subacute care unit shall house patients based on their ages, gender, and/or developmental levels, and/or social needs in a manner planned to promote the growth and development of all those housed together.

(f) The facility shall provide for a comprehensive developmental assessment for each pediatric subacute care patient who is under 36 months of age. The assessment shall be performed by a qualified professional with training and expertise specific to the assessment of, and program planning for, infant and child development. The professional who performs the developmental assessment shall:

(1) Assess the patient's abilities and needs in at least the following areas, where applicable, within 14 calendar days of admission to the pediatric subacute care unit:

(A) Sensorimotor development including gross motor skills, fine motor skills and visual motor perception;

(B) Social development and cognitive development;

(C) Self-help development including developmentally appropriate feeding, toileting, dressing, and grooming;

- (D) Language and communication skills; and
 - (E) Play and recreation needs.
- (2) Prepare a developmental program for each patient with specific goals and plan of activities to reach each goal;
 - (3) Provide direct developmental services to patients in accordance with the developmental program;
 - (4) Provide ongoing instruction to pediatric subacute direct patient care unit staff on the daily activities required to facilitate continuity of the developmental program;
 - (5) Monitor the progress of the patient in reaching the goals of the developmental program, reassess the patient and revise the developmental program at appropriate intervals, but at least quarterly;
 - (6) Maintain a record of the developmental program in the patient's medical chart, including regular progress notes;
 - (7) Participate in the interdisciplinary team conferences;
 - (8) Provide family training as appropriate;
 - (9) Make recommendations to the Service Coordinator, as provided for in (j) of this Section, regarding the provision of continuing developmental services prior to the patient's discharge to a lower level of care.
- (g) The facility shall incorporate each patient's developmental program into the comprehensive nursing care plan for each patient. The nursing care plan shall be revised based on changes in the developmental program.
- (h) In accordance with (j)(3) of this Section, the facility shall work with the Local Education Agency in the development and implementation of an Individual Education

Plan (IEP) for each pediatric subacute care patient who is 36 months of age and older. The facility shall incorporate those activities identified in the IEP, as appropriate, into the patient's comprehensive nursing care plan. To facilitate continuity of services, the facility shall obtain instruction from the Local Education Agency for the pediatric subacute direct patient care unit staff in performing activities in the IEP when the child is not in a formal educational session.

(i) In accordance with (j)(3) and (j)(4) of this section, the facility shall work with the Regional Center, as defined in Title 17, California Code of Regulations, Section 54302(a)(43) or the Local Education Agency Provider, as defined in Title 22, California Code of Regulations, Section 51190.2, in the development and implementation of an Individual Family Service Plan (IFSP), as specified in Government Code Section 95020, for each pediatric subacute patient who is under 36 months of age. The facility shall incorporate those identified activities in the IFSP, as appropriate, into the patient's comprehensive nursing plan. To facilitate continuity of services, the facility shall obtain instruction from the Regional Center or Local Education Agency Provider for the pediatric subacute unit staff in performing activities in the IFSP.

(j) Each pediatric subacute care unit shall designate a person or persons as the Service Coordinator whose time is equal, in hours, to one full-time position for every 20 patients. This position shall be dedicated to the pediatric subacute care unit and be separate from the nurse staffing hours required by (k) of this section. The Service Coordinator(s) shall be either a registered nurse or individual with a baccalaureate degree in social work who possesses the knowledge and ability to assess the current needs of each pediatric subacute patient and the available resources in the facility and community to meet those needs. The Service Coordinator's activities shall include, but not be limited to:

- (1) Coordination of patient admission activities;
- (2) Liaison between the patient, family members, the interdisciplinary team and community to assure that services to meet the patient's needs are initiated and met in accordance with their plans of care and treatment;
- (3) Referral to and collaboration with Early Intervention Programs as described in the Individuals with Disabilities Education Act, 20 United States Code, Section 1400, et seq., Early Intervention Program, 20 United States Code, Section 1471, and with Special Education Programs, as described in the California Education Code, Section 56000 et seq.;
- (4) Coordination with local or state agencies and programs providing services to children, such as the Regional Center, California Children's Services, Child Protective Services;

(5) Coordination of patient and family teaching;

(6) Preparation and implementation of a discharge plan for each patient's return home, to other appropriate placement or leave of absence. This shall include the identification and arrangement of services and equipment for the patient to effectuate discharge or leave of absence;

(k) Pediatric subacute care units shall define, implement, and maintain a system for determining patient requirements for nursing care based on patient needs with goals that are time limited, as demonstrated in each patient's comprehensive care plan. Nursing personnel shall be sufficient to assure prompt recognition of any untoward change in patient condition, and to facilitate appropriate nursing, medical or other appropriate intervention. The pediatric subacute care unit shall utilize nursing staff in at least the following minimum ratios: a minimum daily average of 5.0 actual unduplicated licensed nursing hours per patient day, and 4.0 actual certified nurse aide hours per patient day.

(l) In providing for the licensed nursing hours requirement in accordance with subsection (k) of this section, each pediatric subacute unit shall provide:

(1) A registered nurse as the pediatric subacute unit's head nurse/nurse manager;
and

(2) A minimum of one registered nurse per shift, not including the unit's head nurse/nurse manager, unless at least 80% of the time of that nurse is spent in direct patient care. In such a case, the remaining 20% of time of that nurse shall be spent in managerial duties for the pediatric subacute unit.

(m) The head nurse/nurse manager shall upon hire provide to the employer evidence specified in subsections (m)(1) and (2) below:

(1) Current California licensure as a registered nurse, and a minimum of two years experience within the last five years which shall include nursing supervision, and providing care to the types of pediatric patients with technology dependency for whom the facility provides care; and

(2) Within one year of his/her date of hire, proof of completion of at least 30 continuing education units specific to the physical and psycho-social assessment of, and provision of care to, the critically ill child.

(n) Each licensed nurse shall provide to the employer evidence of either of the following:

(1) Upon hire, a minimum of six months experience within the past two years providing care to the types of pediatric subacute patients with technology dependency for whom the facility provides care; or

(2) An acquired competency, to be documented in the licensed nurse's personnel records, including:

(A) Proof of completion of at least 15 continuing education units specific to the provision of care to the critically ill child within one year of his/her date of hire, and

(B) Proof of completion, within two months of employment, of at least 40 hours of direct employee specific preceptorship, provided by a registered nurse meeting the qualifications specified in Section 51215.8(m), designed to promote the licensed nurse's clinical competency in providing nursing services to the types of pediatric patients with technology dependency for whom the facility provides care. The preceptorship may be provided during the licensed nurse's normal working tour of duty.

(o) All pediatric subacute care licensed and certified nursing staff shall either have upon hire, or prior to the completion of the orientation period described in Title 22, Section 72517(d), obtain and subsequently maintain, pediatric cardiopulmonary resuscitation certification.

(p) The registered nurse member of the pediatric subacute care licensed nursing staff on each shift shall either have upon hire, or within 90 calendar days of his/her date of hire, obtain and subsequently maintain, pediatric advanced cardiopulmonary resuscitation life support certification.

(q) No nursing staff person assigned to the pediatric subacute unit, including the unit's head nurse/nurse manager, shall be assigned duties outside of the pediatric subacute care unit during any given shift when the staff person is assigned to the pediatric subacute unit.

(r) In complying with the staff development requirements specified in Section 72517(a)(1), the facility shall focus on the nursing care and developmental needs of pediatric patients for whom it provides care. The facility shall maintain documentation of compliance with this section and provide it upon request by the Department.

(s) Each nurse aide assigned to the pediatric subacute care unit shall meet the nurse aide certification requirements set forth in Sections 71801 through 71853.

(t) The pediatric subacute care unit shall utilize a licensed Respiratory Care Practitioner to provide a minimum of 3.0 hours per patient day to each ventilator dependent patient, and a minimum of 2.0 hours per patient day to each non-ventilator dependent patient, of medically necessary respiratory care services, when provided under the order of a person lawfully authorized to give such an order, and according to each pediatric subacute beneficiary's assessment and care plan. A licensed Respiratory Care Practitioner shall be present in the nursing facility 24 hours a day and may have assigned duties outside the pediatric subacute care unit.

(u) Each facility providing pediatric subacute services shall provide for the consultant services of a registered dietician with demonstrated background and/or clinical experience in pediatric nutrition. The pediatric registered dietician shall provide a comprehensive nutrition assessment within seven working days of the child's admission to the pediatric subacute unit followed by development and implementation of a nutrition care plan in accordance with accepted pediatric nutrition standards of care.

s 51215.9. Pediatric Subacute Care Unit -Physician Services.

(a) Physician services shall be provided in a pediatric subacute care unit in accordance with Section 72303, Title 22, California Code of Regulations, with the exception of (b)(1) of that section, and in accordance with (a) and (b) of this section.

(b) Each pediatric subacute patient's attending physician shall perform an initial history and physical examination of the patient and prepare a written report of the examination within 24 hours of the patient's admission to the pediatric subacute care unit. In addition to documentation of history and physical examination, this report shall include a plan of treatment that addresses, at a minimum, the following areas:

- (1) The patient's level of function;
- (2) History of dependence on and potential for weaning from medical technology(ies);

(3) Nutritional status, including growth history, anthropometric status and dietary needs; and

(4) Need for physical therapy, occupational therapy or speech therapy assessment and services.

(c) Medi-Cal beneficiaries receiving pediatric subacute care services shall be visited by their attending physician at least twice weekly during the first month of stay, and at a minimum of once each week thereafter, and more often as the patient's condition warrants.

(d) A certified pediatric nurse practitioner or certified family nurse practitioner may, in collaboration with the pediatric subacute care unit patient's attending physician, provide non-duplicative services to pediatric subacute care unit patients within the scope of their practice requirements.

(e) Each pediatric subacute care unit shall have a medical director who is a pediatrician currently certified by the American Board of Pediatrics, with demonstrated experience in caring for pediatric patients with dependence on medical technology. This requirement shall apply to a physician who has assumed the responsibility of medical director of a pediatric subacute care unit on or after the adoption date of this regulation. The pediatric subacute care unit medical director shall:

(1) Act as liaison between facility administration and physicians attending pediatric subacute patients;

(2) Be responsible for reviewing and evaluating pediatric subacute administrative and medical care policies and procedures;

(3) Act as a consultant to the head nurse/nurse manager in matters relating to pediatric subacute patient care services;

(4) Provide attending physician services to all pediatric subacute patients in the event of the absence or non-availability of other attending physicians;

(5) Be responsible for reviewing pediatric subacute unit employees' preemployment and annual health examination reports.

s 51215.10. Pediatric Subacute Care Unit -Rehabilitation Therapy Services.

(a) Each pediatric subacute care unit shall define, implement and maintain a system for assessing and meeting patient needs for all appropriate physical, occupational and speech therapy services including supportive and maintenance programs. The appropriate therapist shall develop a plan of treatment, as specified in (g) or (j) of this section, which shall be integrated into an individualized comprehensive plan of care consistent with an interdisciplinary team approach in meeting each child's needs.

(b) The following definitions shall apply only to this section:

(1) "Physician" shall mean a licensed medical doctor who is a pediatric physiatrist or a physician with knowledge and experience in the rehabilitation of infants, children and adolescents.

(2) "Therapist" shall mean a licensed or registered physical therapist, occupational therapist or speech pathologist with experience in pediatric rehabilitation services.

(c) Each pediatric subacute care patient shall receive, not more than 14 calendar days prior to, or within seven calendar days after admission to a pediatric subacute care unit, a complete rehabilitation assessment performed by a physician. Such assessment shall reflect the actual status of the child at the time of admission to the pediatric subacute care unit and shall be repeated as clinically indicated by change in functional or cognitive status of the child.

(d) In addition to the complete rehabilitation assessment specified in (c) of this section, the physician shall, based on functional potential and maintenance needs of the pediatric subacute care patient, develop and recommend a program of therapy to be provided after admission to the pediatric subacute care unit.

(e) Each pediatric subacute care patient shall receive a physical therapy and occupational therapy assessment and have a plan of treatment developed by the appropriate therapist reflective of the medical recommendations specified in (d) of this section, within 14 days of admission to the pediatric subacute care unit, unless medically contraindicated and documented as such in the medical record. Subsequent physical therapy and occupational therapy assessments shall be performed quarterly or more often as clinically indicated.

(f) A speech therapy assessment shall be provided to pediatric subacute care patients as medically indicated and a plan of treatment developed that identifies measurable functional goals within specific time frames.

(g) For each pediatric subacute care patient, in developing the plan of treatment specified in (e) of this section, the therapist shall:

(1) Develop, periodically review and revise a time limited, goal oriented plan of supportive or maintenance interventions;

(2) Instruct appropriate pediatric subacute care unit staff on the provision of the interventions.

(h) The therapy services specified in (e) through (g) of this section shall be considered a part of the pediatric subacute care services authorized in accordance with Section 51335.6(c).

(i) In addition to the therapy services as specified in (e), (f) and (g) of this section, supplemental rehabilitation therapy services provided in a pediatric subacute care unit may be covered separately for pediatric subacute care patients who, as determined by the physician who performs the assessment specified in (c) of this section:

(1) Can tolerate a minimum of four hours per week of any combination of direct therapy provided by or under the direct supervision of a therapist as specified in (b) of this section.

(2) Demonstrate the potential to achieve, or continue to achieve, measurable functional goals within specific time frames in such areas as mobility, activities of daily living or the reduction of nursing care.

(i) For each pediatric subacute care patient for whom supplemental rehabilitation therapy services are requested, the physician shall participate in the continuing rehabilitation plan of treatment by providing ongoing rehabilitation consultation and direction to the rehabilitation therapy staff in addition to the review and approval of the rehabilitation plan of treatment.

(k) For each pediatric subacute care patient for whom supplemental rehabilitation therapy services are requested, in addition to the requirements to (e), (f) and (g), the therapist shall document in the supplemental rehabilitation therapy plan of treatment:

(1) The specific type, number and frequency of direct therapy services to be performed by or under the direct supervision of the appropriate therapist;

(2) Therapeutic goals of the services provided by each discipline and anticipated duration of treatment.

(l) Supplemental rehabilitation therapy services shall be covered separately from the pediatric subacute care services authorized in accordance with Section 51335.6(c).

(m) Supplemental rehabilitation therapy services shall be subject to the standards of medical necessity as set forth in Sections 51303(a) and 51340(e). Authorization requests shall be initiated by the facility.

(1) For the initial requests for supplemental rehabilitation therapy services, a treatment authorization request (TAR) shall be submitted within 10 working days of the development of the patient's plan of treatment accompanied by the documentation as required by the Department.

(2) For reauthorization or requests for continuation of supplemental rehabilitation therapy services, a TAR shall be accompanied by a statement describing the pediatric subacute care patient's progress and documentation demonstrating the continued medical necessity of these services.

s 51215.11. Pediatric Subacute Care Unit -Ventilator Weaning.

(a) Each pediatric subacute care unit shall define, implement and maintain a system for assessing, on admission and at least quarterly, those pediatric patients who are dependent, in part or completely, on mechanical ventilation for the appropriateness of reduction or elimination of such dependence.

(b) Ventilator weaning services performed in the pediatric subacute care unit shall be covered separately for the purpose of decreasing or eliminating dependence on mechanical ventilation, subject to the following criteria:

(1) The pediatric subacute care patient shall be evaluated and deemed appropriate for a weaning trial by a physician with knowledge of and experience in pediatric mechanical ventilation care and who documents, at a minimum, the history of ventilator

dependence, previous weaning attempts, and a description of the weaning plan of treatment specifying measurable functional goals within specified time frames and post-weaning stabilization care intensity and duration.

(2) The appropriate health care professional, as the result of a comprehensive patient assessment, shall develop a plan of treatment which shall be integrated into an individualized comprehensive plan of care consistent with an interdisciplinary team approach in meeting the child's needs. A plan of treatment specifying measurable functional goals within specified time frames shall include but not be limited to:

(A) A respiratory care practitioner's plan of treatment that provides documentation of needed respiratory care practitioner time greater than the three hours in a day, as required by Section 51215.8(t).

(B) A nursing plan of treatment that documents the need for registered nurse assessments and subsequent skilled nursing care interventions at specified intervals, but in any case, more than three times in every 24 hours.

(c) Ventilator weaning services shall be covered separately from the pediatric subacute care services authorized in accordance with Section 51335.6(c).

(d) Ventilator weaning requests shall be subject to the standards of medical necessity as set forth in Sections 51303(a) and 51340(e). Authorization requests shall be initiated by the facility.

(1) For the initial request for ventilator weaning, a treatment authorization request (TAR) shall be submitted within 10 working days of the development of the patient's plan of treatment accompanied by the documentation in (b) of this section as appropriate.

(2) For reauthorization or requests for continuation of ventilator weaning, a TAR shall be accompanied by a statement describing the pediatric subacute care patient's progress and decreased ventilator dependence achieved and the information required in (b)(1) of this section updated to document continued medical necessity of these services.

(3) Pediatric subacute care patients for whom ventilator weaning is authorized shall remain eligible for pediatric subacute care services authorized in accordance with Section 51335.6(c) for the duration of authorization period for ventilator weaning.

s 51216. Transfer of Ownership.

In the case of a transfer of the ownership of an institutional provider of service (includes hospital, skilled nursing facility, intermediate care facility, and home health agency), the new owner shall not be considered as an eligible provider earlier than thirty days following notice of a change of ownership or proposed change of ownership. The notice shall be in writing and shall be submitted to the Department. If the interests of the state are adequately protected, the Department may authorize shortening the 30-day period or waiving the notice requirement.

s 51217. Home Health Agency.

A home health agency shall:

(a) Be licensed by the Department according to applicable laws and regulations and,

(b) Meet the standards for Medicare participation in Title 42 Code of Federal Regulations, Part 405 Subpart L or be certified under Title XVIII or XIX of the federal Social Security Act.

s 51218. Renal Dialysis Centers, Community Hemodialysis Units and Renal Homotransplantation Centers.

Renal dialysis centers, community hemodialysis units and renal transplantation centers shall:

(a) Be certified for and participate in the Medicare program.

(b) Meet standards established by the Department and be certified by the Department to participate in the Medi-Cal program.

(c) Be recommended for certification by the areawide comprehensive health planning agency on the basis of community need.

s 51219. Audiologist.

An audiologist shall be licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the State in which he practices.

s 51220. Chiropractor.

A chiropractor shall be licensed to practice by the California Board of Chiropractic Examiners or similarly licensed by a comparable agency in the state in which he practices.

s 51220.5. Acupuncturist.

An acupuncturist shall be certified to practice acupuncture in California by the Division of Allied Health Professions of the California Board of Medical Quality Assurance or be similarly certified by a comparable agency of the state in which the acupuncturist practices.

s 51221. Christian Science Facilities.

A Christian Science facility shall annually provide the Department with evidence that they are currently certified by the First Church of Christ Scientist, Boston, Massachusetts.

s 51222. Christian Science Practitioner.

A Christian Science practitioner shall:

(a) Be listed in the Christian Science Journal, published by the First Church of Christ Scientist, Boston, Massachusetts, as a practitioner;

(b) Meet the requirements of the First Church of Christ Scientist relating to billing the Medi-Cal Program for services rendered.

s 51223. Dentist.

(a) A dentist shall be licensed to practice dentistry by the California Board of Dental Examiners or similarly licensed by a comparable agency in the state in which he practices.

(b) A qualified oral surgeon shall be a dentist who meets the requirements of (1) and either (2) or (3).

(1) Confines his practice to the specialty of oral surgery.

(2) Has successfully completed a course of advanced study in oral surgery of three years or more in programs recognized by the Council on Dental Education of the American Dental Association.

(3) Has completed advanced training in oral surgery and meets both of the following requirements:

(A) Has had advanced study and hospital experience in performing oral surgery in maxillofacial deformities and temporomandibular joint dysfunction.

(B) Is listed in the Directory of the American Dental Association with the Specialty Code of 10, as defined in the 1977 issue.

(c) A qualified orthodontist shall be a dentist who meets the requirements of (1) and either (2) or (3).

(1) Confines his practice to the specialty of orthodontics.

(2) Has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association.

(3) Has completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontists.

(d) A qualified maxillofacial prosthodontist shall be a dentist who meets the requirements of (1) and either (2) or (3).

(1) Provides maxillofacial prosthetic services to the general public as an integral part of his practice.

(2) Is a Fellow or an Associate Fellow of the American Academy of Maxillofacial Prosthetics.

(3) Is a member of or eligible for membership in the American Board of Prosthodontics.

(e) A qualified practitioner in temporomandibular joint dysfunction management shall be a dentist who:

(1) Provides temporomandibular joint pain diagnosis and treatment services to the general public as an integral part of his practice.

(2) Has had advanced training in providing temporomandibular joint pain diagnosis and treatment.

s 51224. Dental School Clinic.

A dental school clinic shall be under the direction of a dental school which has been approved by the California Board of Dental Examiners.

s 51224.5. Durable Medical Equipment and Medical Supply Providers.

(a) As a condition for enrollment, or continued enrollment, in the Medi-Cal program, an applicant or provider of durable medical equipment and medical supplies shall:

(1) Maintain a business address, as defined in Section 51000.3, that is accessible to the general public. Each provider shall keep, maintain, and have readily retrievable at their business address those records specified in Section 51476.

(2) Maintain a business telephone, as defined in Section 51000.4, at the business address. The business telephone number shall be listed under the name of the business and in the business portion of the local telephone company directory.

(3) Maintain comprehensive liability insurance that covers both the applicant's or provider's place of business and any and all customers and employees of the applicant or provider.

(4) Fill orders from its inventory or by contracting with other companies for the purchase of items necessary to fill the order. Items may be fabricated or fitted for sale only from supplies purchased under contract.

(5) Obtain and maintain all state and local licenses and permits necessary to provide the services, goods, supplies, or merchandise being provided, including but not limited to, the licenses specified below:

(A) One or more of the licenses issued by the Bureau of Home Furnishings and Thermal Insulation of the Department of Consumer Affairs, as applicable to the applicant's or provider's business activity:

1. If the applicant or provider intends to rent or currently rents beds, a Sanitizer's License, a Furniture and Bedding Manufacturer's License, a Custom Upholsterer's License, a Retail Furniture and Bedding Dealer's License, or a Retail Bedding License.

2. If the applicant or provider intends to sell, or currently sells beds, a Retail Bedding Dealer's License, an Importer's License, a Furniture and Bedding Manufacturer's License, a Wholesale Furniture and Bedding Dealer's License, or a Retail Furniture and Bedding Dealer's License.

3. If the applicant or provider intends to sell, or currently sells wheelchairs, a Retail Furniture Dealer's License, an Importer's License, a Furniture and Bedding Manufacturer's License, a Wholesale Furniture and Bedding Dealer's License, a Custom Upholsterer's License, or a Retail Furniture and Bedding Dealer's License.

(B) Licenses issued by the Board of Pharmacy entitled "Medical Device Retailer Original Certificate," and "Medical Device Retailer Original Exemptee Certificate," if the

applicant or provider intends to provide, or currently provides, ostomy supplies, oxygen equipment and supplies, urinary catheters, bags, and related supplies.

(6) Have written policies and/or procedures that ensures all the following:

(A) Beneficiaries shall be advised that:

1. Medi-Cal may approve rental or purchase of durable medical equipment on behalf of the beneficiary.

2. Except for life support equipment, such as ventilators, when previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and no further reimbursement to the provider shall be made for the beneficiary's use of the item, unless repair and maintenance is separately authorized.

(B) All warranties, expressed and implied, shall be honored and neither the beneficiary nor the Medi-Cal program shall be charged for the repair or replacement of Medi-Cal covered items or for services covered under warranty.

(C) Beneficiaries shall be provided with necessary information and instructions on how to use items safely and effectively.

(D) Questions or complaints from beneficiaries about items that are sold or rented shall be responded to within 10 calendar days of the date the beneficiary contacts the provider.

(E) Maintenance and/or repair of items shall be provided directly, or through a service contract with another company.

(F) Returns of substandard or unsuitable items shall be accepted from beneficiaries. Substandard or unsuitable items shall be replaced by the provider at no additional cost to the beneficiary or the Medi-Cal program. For the purposes of this section only, the following shall apply:

1. A "substandard item" shall have the same meaning specified in Section 14043.1, Welfare and Institutions (W&I) Code.

2. An "unsuitable item" is an item that, when in actual use, does not meet the medical needs of the beneficiary when the beneficiary's medical condition has not significantly changed since the item was fitted or sold.

(G) In addition to the written policies and procedures specified in (A) through (F), above, a durable medical equipment and medical supply applicant or provider who holds a license as a medical device retailer, or a medical device retailer exemptee, and provides dangerous drugs or dangerous devices, as defined in Section 4022, Business and Professions (B&P) Code, shall meet the standards specified in Section 4131, B&P Code, and have written policies and procedures that meet the requirements of Section 4132, B&P Code.

(b) Consumer information, such as copies of warranties and product information, a copy of the written policies and/or procedures required by subsection (a)(6), above, and a copy of the participation standards specified in this Section shall be provided to each beneficiary to whom a Medi-Cal reimbursed item is provided.

(c) Applicants and enrolled providers shall be subject to an onsite inspection, as permitted by Section 14043.37, W&I Code, or an unannounced visit, as permitted by Section 14043.7, W&I Code, to ensure the requirements of this section have been met.

s 51225. Orthotist.

An orthotist shall be certified in orthotics by either the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

s 51225.5. Respiratory Care Practitioner.

(a) A respiratory care practitioner shall:

(1) be licensed by the Respiratory Care Board of California or similarly certified by a comparable agency in the state in which he or she practices, and

(2) have a Registered Respiratory Therapist credential from the National Board of Respiratory Care.

(b) In addition to the requirements under subsection (a), a respiratory care practitioner who performs cardio-pulmonary resuscitation (CPR) shall have successfully completed a cognitive and skills examination in accordance with the curriculum of the American Red Cross or the American Heart Association, every two (2) years, and shall have available for review a valid CPR certification.

(c) In addition to the requirements under subsection (a), a respiratory care practitioner who performs electrocardiograph (EKG) procedures shall have available for review by the Department a letter from a supervising physician certifying that he or she has received training and is competent to perform EKG procedures.

(d) Respiratory care practitioners shall abide by the "Ethical Performance of Respiratory Home Care", effective April 1983 and the "Statement of Principles on Fraud and Abuse in Home Care", effective July, 1991 of the American Association of Respiratory Care (AARC), as stated in the AARC Position Statements published in 1995.

s 51226. Pharmacy.

A pharmacy shall have a valid permit issued by the California Board of Pharmacy pursuant to Sections 4035 and 4035.1 of the Business and Professions Code or have a similar permit issued by the state in which it is located.

s 51227. Pharmacist.

A pharmacist shall hold a valid certificate issued by the California Board of Pharmacy pursuant to Section 4085 of the Business and Professions Code, or hold a similar valid certificate issued by the State in which he practices.

s 51228. Physician.

A physician shall be licensed as a physician and surgeon by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners or similarly licensed by a comparable agency of the state in which he practices.

s 51229. Podiatrist.

A podiatrist shall be licensed to practice podiatry by the California Board of Medical Quality Assurance, or shall be similarly licensed by a comparable agency of the state in which he practices.

s 51230. Prosthetist.

A prosthetist shall be certified in prosthetics by either the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

s 51231. Ambulance Requirements.

(a) Ambulances shall be licensed, operated and equipped in accordance with applicable federal, state and local statutes, ordinances and regulations.

(b) Ambulances operated in other states shall comply with applicable federal, state and local statutes, ordinances and regulations.

s 51231.1. Litter Van Requirements.

(a) Litter vans shall be operated by a certified driver and an attendant.

(1) These persons shall:

(A) Possess a current California driver's license or a current California Ambulance Driver Certificate issued by the State Department of Motor Vehicles.

(B) Be at least 18 years of age.

(C) Possess at least a current American Red Cross Standard First Aid and Personal Safety Certificate or equivalent.

(D) Have passed a physical examination within the past two years and possess a current Department of Motor Vehicle form DL-51, Medical Examination Report, which is specifically incorporated herein by reference.

(E) Not act in the capacity of a driver or attendant when such person:

1. Is required by law to register as a sex offender for any offense involving force, duress, threat or intimidation.

2. Habitually or excessively uses or is addicted to narcotics or dangerous drugs, or has been convicted during the preceding seven years of any felony offense relating to the use, sale, possession or transportation of narcotics, addictive or dangerous drugs or alcohol .

3. Habitually or excessively uses intoxicating beverages.

(b) Litter vans shall be equipped with at least the following:

(1) Loading entrance large enough to accommodate a patient comfortably lying on a standard-sized gurney.

(2) Emergency exit, other than loading entrance, that can accommodate a standard-sized gurney.

(3) Locking devices for all doors and all door latches which shall be operable from inside and outside on all vehicles manufactured and first registered after January 1, 1980.

(4) Approved seat belt assemblies for the driver and attendant.

(5) Fasteners to secure the gurney to the vehicle which must be of sufficient strength to prevent the gurney from rolling or sliding, to prevent the gurney from leaving the floor in case of sudden movement and to support the gurney and patient in the event the vehicle is overturned.

- (6) One interior light.
 - (7) Portable, battery operated light.
 - (8) Controlled heating and air conditioning system in the passenger compartment.
 - (9) Seats covered with washable vinyl or similar impermeable material which shall be in sanitary and functional condition.
 - (10) Spare wheel, jack and tire tools necessary to make minor repairs except when operating where service and repair cars are immediately available.
 - (11) Current maps of the streets in the area where service is provided.
 - (12) Fire extinguisher, type 4-B:C dry powder or carbon dioxide. Vaporizing liquid extinguishers shall not be used.
 - (13) Identification display of the name under which the litter van is doing business or providing service, on both sides and the rear of each litter van in letters that contrast sharply with the background. Lettering for upper case letters shall be not less than four inches in height, or proportionate width, and of a color readily visible during daylight. Lower case letters shall be no less than three-fourths of the upper case height. All litter vans operated under a single license shall display the same identification. A litter van shall not display identification as an ambulance.
 - (14) One two-man gurney with mattress and upper and lower restraining straps.
 - (15) Cot fastener, floor or wall type.
 - (16) Attendant seat in patient compartment.
- (c) Litter vans may be used as wheelchair vans if the litter van meets all the requirements for a wheelchair van as listed in Section 51231.2.

(d) Litter van providers shall be licensed, operated and equipped in accordance with applicable federal, state and local statutes, ordinances and regulations.

(e) Litter van providers in other states shall comply with applicable federal, state and local statutes, ordinances and regulations.

(f) All litter van patients shall be secured to gurney by restraining belts while being loaded, unloaded and transported.

(g) The driver or attendant shall not smoke in the litter van while transporting a patient.

(h) Litter van providers shall furnish the following information to the local Medi-Cal Field Office on an annual basis:

(1) Statement of hours of operation and geographic area served.

(2) Standard brake and light certificate issued by the Department of Consumer Affairs within 45 days following the annual renewal date.

s 51231.2. Wheelchair Van Requirements.

(a) Wheelchair vans shall be operated by a certified driver and, where applicable, an attendant.

(1) These persons shall:

(A) Possess a current California driver license or a current California Ambulance Driver Certificate issued by the State Department of Motor Vehicles.

(B) Be at least 18 years of age.

(C) Possess at least a current American Red Cross Standard First Aid and Personal Safety Certificate or equivalent.

(D) Have passed a physical examination within the past two years and possess a current Department of Motor Vehicle form DL-51, Medical Examination Report, which is specifically incorporated herein by reference.

(E) Not act in the capacity of a driver or attendant when such person:

1. Is required by law to register as a sex offender for any offense involving force, duress, threat or intimidation.

2. Habitually or excessively uses or is addicted to narcotics or dangerous drugs, or has been convicted during the preceding seven years of any felony offense relating to the use, sale, possession or transportation of narcotics, addictive or dangerous drugs or alcohol.

3. Habitually or excessively uses intoxicating beverages.

(b) Wheelchair vans shall be equipped with at least the following:

(1) One standard-sized wheelchair.

(2) Loading entrance large enough to accommodate a patient comfortably seated in a standard-sized wheelchair.

(3) Emergency exit, other than loading entrance, that can accommodate a standard-sized wheelchair.

(4) Locking devices for all doors and all door latches which shall be operable from inside and outside on all vehicles manufactured and first registered after January 1, 1980.

(5) Seating capacity to accommodate at least two patients seated in standard-sized wheelchairs.

(6) Approved seat belt assemblies for the driver and any front seat passengers.

(7) Fasteners to secure the wheelchair to the vehicle which must be of sufficient strength to prevent the chairs from rotating, to prevent the chair wheels from leaving the floor in case of sudden movement and to support the chairs and patients in the event the vehicle is overturned.

(8) Lift or ramp with a load capacity of at least 450 pounds which can be secured to the vehicle.

(9) Foot stool or extra step for loading.

(10) One interior light.

(11) Portable, battery-operated light.

(12) Controlled heating and air conditioning system in the patient compartment.

(13) Seats covered with washable vinyl, or similar impermeable material which shall be in sanitary and functional condition.

(14) Spare wheel, jack and tire tools necessary to make minor repairs except when operating where service and repair cars are immediately available.

(15) Current maps of the streets in the area where service is provided.

(16) Fire extinguisher, type 4-B:C dry powder or carbon dioxide. Vaporizing liquid extinguishers shall not be used.

(17) Identification display of the name under which the wheelchair van is doing business or providing service, on both sides and rear of each wheelchair van in letters that contrast sharply with the background. Lettering for upper case letters shall be not less than four inches in height, or proportionate width, and of color readily visible during daylight. Lower case letters shall be no less than three-fourths of the upper case height.

All wheelchair vans operated under a single license shall display the same identification.

(c) Wheelchair van providers shall be licensed, operated and equipped in accordance with applicable federal, state and local statutes, ordinances and regulations.

(d) Wheelchair van providers in other states shall comply with applicable federal, state and local statutes, ordinances and regulations.

(e) All wheelchair passengers must be secured to wheelchairs while being loaded, unloaded or transported.

(f) Neither driver nor attendant shall smoke in the wheelchair van.

(g) Wheelchair van providers shall furnish the following information to the local Medical Field Office on an annual basis:

(1) Statement of hours and geographic area served.

(2) Standard brake and light certificate issued by the Department of Consumer Affairs within 45 days following the annual renewal date.

s 51232. Psychologist.

A psychologist shall be licensed by the Psychology Examining Committee of the State Board of Medical Quality Assurance or be similarly licensed by a comparable agency in the State in which he practices.

s 51233. Optometrist.

An optometrist shall be licensed by the California Board of Optometry to practice optometry, or be similarly licensed by a comparable agency of the state in which he practices.

s 51234. Psychiatric Technician.

s 51235. Dietitian.

s 51236. Radiological and Radioisotope Services.

Diagnostic and therapeutic radiological and radioisotope services shall only be provided pursuant to the registration or licensing provisions of Chapter 5, subchapters 4, and 4.5 of Title 17, California Administrative Code, or with similar registration or licensing provisions of a similar agency of the state in which the service is rendered.

s 51237. Nurse Anesthetist.

A nurse anesthetist shall be licensed as a registered nurse by the California Board of Registered Nursing, or similarly registered or licensed by a comparable agency in the state in which he practices, and certified by the American Association of Nurse Anesthetists.

s 51238. Short-Doyle Medi-Cal Provider.

A Short-Doyle Medi-Cal provider shall be approved by the Department to participate in the Short-Doyle Medi-Cal program.

s 51239. Outpatient Heroin Detoxification Provider.

(a) Outpatient heroin detoxification services shall be provided only by or through one of the following:

(1) Persons or facilities approved to provide such treatment under the provisions of Subchapter 6, Title 9, California Administrative Code.

(2) Persons or facilities approved to conduct research programs under the provisions of Section 11481, Health and Safety Code, and Subsection 4351 (a), Welfare and Institutions Code.

(3) Organized outpatient clinics appropriately licensed under the provisions of Section 400, Title 17, California Administrative Code.

(4) Hospital outpatient departments appropriately licensed under the provision of Section 70103, Title 22, California Administrative Code.

(5) Physicians providing office heroin detoxification services.

(b) Providers of heroin detoxification services shall comply with the requirements of the appropriate State of California Codes, including but not limited to the following, as a condition for reimbursement when using a drug for heroin detoxification purposes which is covered by any of these codes:

(1) Chapter 6, Title 9, California Administrative Code.

(2) Section 11481, Subsection 4351, Health and Safety Code.

(3) Sections 26670, 26678 or 26679, Health and Safety Code.

s 51240. Utilization of Nonphysician Medical Practitioners.

(a) Each primary care physician, organized outpatient clinic or hospital outpatient department which utilizes a qualified nonphysician medical practitioner shall complete a "Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application," DHS 6248 (Rev. 07/05) for enrollment in the Medi-Cal program pursuant to Section 51000.30.

(b) The number of nonphysician medical practitioners who may be supervised by a single primary care physician shall be limited to the full-time equivalent of one of the following:

(1) Four nurse practitioners.

(2) Three nurse midwives.

(3) Two physician's assistants.

(4) Four of the above individuals in any combination which does not exceed the limit stated in either subparagraph (2) or (3).

(c) A primary care physician, an organized outpatient clinic or a hospital outpatient department shall not utilize more nonphysician medical practitioners than can be supervised within the limits stated in (b).

(d) Each primary care physician organized outpatient clinic or hospital outpatient department which utilizes a nonphysician medical practitioner shall develop a Physician-Practitioner Interface specifically establishing the scope and limits of services to be rendered by, and related to the functions of, each nonphysician medical practitioner.

(1) A Physician-Practitioner Interface includes the following:

(A) In the case of registered nurses, standardized procedures, as required by Title 16, Article 7, Division 14, California Code of Regulations, commencing with Section 1470.

(B) In the case of physician assistants, a written delegation of medical services and written supervisory guidelines, as required by Section 1399.540 and Section 1399.545(e), Title 16, California Code of Regulations.

(C) All written protocols issued by collaboration between the physician and the nonphysician medical practitioner.

(D) All written standing orders of the physician.

(E) All written special orders given by the physician.

(2) Agreements reached in developing the Physician-Practitioner Interface shall be retained on file at the provider's office, readily available for review by the Department.

(e) Each nurse practitioner shall have completed a clinical and didactic educational program of at least six months duration, which shall be:

(1) Of a length of time and focus appropriate to the scope and functions of the area of practice.

(2) Offered in one of the following:

(A) A college or university that offers a baccalaureate or higher degree.

(B) A health care agency that has an academic affiliation with a college or university as specified in (A).

s 51241. Physician Relationship to Nonphysician Medical Practitioners.

(a) The relationship between the physician and the nonphysician medical practitioner shall be that of a shared and continuing responsibility to follow the progress of the patient in a manner which assures the nonphysician medical practitioner's adherence to the limits of the specific professional practice established by law and regulations, while maximizing patient safety, health and well-being.

(b) The supervising physician shall be available to the nonphysician medical practitioners in person or through electronic means to provide supervision to the extent required by California professional licensing laws, necessary instruction in patient management, consultation and referral to appropriate care and services by specialist physicians or other licensed health care professionals, as may be required in each case.

(c) In cases of emergencies as defined in Section 51056, the nonphysician medical practitioner, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician.

(d) In all cases, the nonphysician medical practitioner shall be responsible to maintain reasonable communication with the physician, to keep the physician informed, to follow instructions and, in any case of doubt, to seek assistance or additional instructions.

s 51242. EPSDT Diagnosis and Treatment Provider and EPSDT Supplemental Services Provider.

(a) An EPSDT diagnosis and treatment provider shall meet the requirements for participation in the Medi-Cal program as specified in this chapter, excepting the requirements specified in subsection (b).

(b) A provider seeking to provide EPSDT supplemental services, who is not enrolled as a provider pursuant to subsection (a), shall first submit a provider enrollment application to the department to become an EPSDT supplemental services provider. The application shall be accompanied by a request for prior authorization, pursuant to Section 51340(c), for the initial service the provider seeks to provide.

(c) An EPSDT case manager, defined in Section 51184(h)(4), seeking to provide EPSDT case management services shall be considered to be an EPSDT supplemental services provider and shall comply with the requirements of this section.

(d) In order to be approved as an EPSDT supplemental services provider for the particular service sought, the provider shall supply documentation or other evidence which the Department determines establishes that both of the following conditions are met:

(1) The services to be provided meet the standard of medical necessity set forth in Section 51340(e).

(2) The provider is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide the service pursuant to Division 2 (commencing with section 500) of the Business and Professions Code or is a licensed pediatric day health and respite care facility pursuant to Section 1760 of the Health and Safety Code, and meets any applicable requirements in federal Medicaid law to provide the particular service requested.

(e) Notwithstanding the provisions of paragraph (d)(1), an entity or individual seeking to provide EPSDT case management services pursuant to Section 51340(j)(3) shall supply documentation enabling the Department to determine that both of the following requirements are met:

(1) The criteria specified in Section 51340(f) are met.

(2) The entity or individual is qualified by education, training, or experience to provide EPSDT case management services to the beneficiary.

(f) The Department shall not approve an application pursuant to subsection (b) or (c) of this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner through existing Medi-Cal certified provider types or other Medi-Cal programs.

(g) Once enrolled as an EPSDT supplemental services provider, the provider shall remain enrolled only for the purpose of providing subsequent EPSDT supplemental services within his or her scope of practice, or within the scope of the facility's license, unless disenrolled by provider choice or the Department's administrative action, pursuant to Chapter 3, Division 3, Title 22, California Code of Regulations.

(h) A provider who is currently enrolled as a Medi-Cal services provider shall not be required to enroll as an EPSDT supplemental services provider.

(i) Notwithstanding subsections (a) and (d), a local health department as defined in Section 101185 of the Health and Safety Code or a comprehensive environmental agency as referenced in Section 101275 of the Health and Safety Code may provide onsite investigations to detect the source of lead contamination as an EPSDT supplemental service, as specified in 51340.1(d). To be eligible for payment, the service must be rendered by an individual who is a Registered Environmental Health Specialist registered in accordance with Article 1 of Chapter 4 of Part 1 of Division 104 of the California Health and Safety Code (commencing with Section 106600) and who has been certified in accordance with Section 35005 of Title 17 of the California Code of Regulations as a Certified Lead Inspector/Assessor of the Department.

s 51242.1. EPSDT Supplemental Services Provider -Pediatric Day Health Care Facility.

(a) A pediatric day health care facility, as defined in Section 51184(k)(2), seeking to provide pediatric day health care EPSDT services shall be considered to be an EPSDT supplemental services provider and shall comply with the provisions specified in this section and in Section 51242, except the provisions of subsections (a), (c) and (e). In addition, the pediatric day health care facility shall maintain documentation available for Department review substantiating compliance with all of the provisions of this section.

(b) The pediatric day health care facility shall provide the required EPSDT services specified in Section 1760.6 of the Health and Safety Code, with the exception of Section 1760.6(b)(5).

(c) The pediatric day health care facility shall comply with the personnel requirements specified in Section 1267.13 of the Health and Safety Code. Such personnel, as required to provide the services pursuant to paragraph (b) of this section, shall be:

(1) Licensed, certified or credentialed health professionals acting within their scope of practice who meet the experience requirements specified in this section; and

(2) Present in the facility in sufficient numbers, as determined under the patient classification system defined in Title 22, California Code of Regulations, Section 70053.2, during all hours of facility operation to provide services as prescribed by the attending physician and documented in the individual plan of treatment and to address projected admissions, terminations and emergencies.

(d) In complying with the provisions of paragraph (c) of this section, the following requirements shall apply:

(1) Registered nurse personnel shall upon hire provide to the employer evidence of all of the following:

(A) Current California licensure as a registered nurse, and a minimum of two years of experience within the last five years which includes the provision of nursing services to children with the types of medical conditions for which the facility provides care. For those registered nurses serving in a supervisory capacity, such experience shall include nursing supervision; and

(B) Within one year of his or her date of hire, proof of completion of at least thirty (30) continuing education units specific to the physical and psychosocial assessment of, and provision of nursing services to, children with the types of medical conditions for which the facility provides care.

(2) Licensed nurse personnel, other than registered nurses, shall provide to the employer evidence, upon hire, of a minimum of six months' experience within the past two years providing care to children with the types of medical conditions for which the facility provides care; or an acquired competency, to be documented in the licensed nurse's personnel records, including:

(A) Proof of completion, within one year of his/her date of hire, of at least 15 continuing education units specific to the provision of care to children with the types of medical conditions for which the facility provides care, and

(B) Proof of completion, within two months of employment, of at least 40 hours of direct employee specific preceptorship, provided by a registered nurse meeting the qualifications specified in subsection (1). For purposes of this section "preceptorship" means the pairing of the newly hired nurse with a registered nurse who has met the experience and education qualifications specified in subsection (1), for the purpose of promoting the clinical competency of the newly hired nurse in providing nursing services to the types of patients for whom the facility provides care. Such a preceptorship may be provided during the licensed nurses' normal working tour of duty.

(3) If the facility provides care to a child who is dependent on mechanical ventilation, the facility shall employ a licensed respiratory care practitioner, or a licensed nurse with documented education, preparation and expertise specific to the assessment and treatment of the ventilator dependent child. Such personnel shall be present in the facility during all hours in which the ventilator dependent child is present in the facility.

(4) If the facility utilizes nonlicensed nursing personnel pursuant to Section 1337 of the Health and Safety Code, such personnel shall, upon hire, provide evidence of a minimum of six months' experience within the past year providing care to children with the types of medical conditions for which the facility provides care.

(5) All medical personnel shall:

(A) Have upon hire, and subsequently maintain, pediatric cardiopulmonary resuscitation certification, or

(B) Prior to the completion of the orientation period described in Title 22, California Code of Regulations, Section 72517(d), obtain, and subsequently maintain, pediatric cardiopulmonary resuscitation certification.

(e) The facility shall collaborate with and involve the child's parent, foster parent or legal guardian in the decision making process for all care planning and provision of interventions and treatment at the facility and in the child's home. Such collaboration shall be provided by the director or personnel delegated by the director, and shall involve, at a minimum:

(1) A conference with the child's parent, foster parent or legal guardian to be held quarterly, or more frequently as indicated by the needs of the child or parent, foster parent or legal guardian, to provide, at a minimum:

- (A) A written status report on the plan of treatment of the child at the facility.

 - (B) Information on the interventions and treatments specified in the child's plan of treatment.
- (2) A written report of the day's events provided to the parent, foster parent or legal guardian at the conclusion of each day of attendance specifying information including but not limited to:
- (A) Treatments provided and when they were provided.

 - (B) Medications administered, including amount, time and route of dosage.

 - (C) Nutritional intake, including amount, time and route of intake.

 - (D) Developmental activities.

 - (E) Contact with the attending physician.
- (f) The facility shall work in conjunction with the Regional Center, as defined in Title 17, Section 54302(a)(49), or the Local Education Agency Provider, as defined in Title 22, Section 51190.2, in the development and implementation of an age appropriate Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) and/or Individualized Health and Support Plan (IHSP) as specified in Government Code Section 95020, for each child. The facility shall incorporate those identified activities in the IFSP, IEP, and/or IHSP as appropriate, into the individual plan of treatment. To facilitate continuity of services, the facility shall obtain instruction for its personnel from the Regional Center or Local Education Agency Provider in performing activities identified in the IFSP, IEP, and/or IHSP.
- (g) During any work shift, personnel employed by the facility shall not be simultaneously assigned duties at a licensed health care facility, including but not limited to, a skilled nursing facility or a congregate living health facility as defined in Division 2, Chapter 2, commencing with Section 1250 of the Health and Safety Code.

(h) The facility shall accept and retain only those beneficiaries for whom it can provide adequate, safe, therapeutic and effective care as determined by the attending physician and documented in the child's individualized plan of treatment.

(i) Pharmaceutical services, as required by paragraph (b) of this section, shall be:

(1) Supplied to the licensed nursing personnel of the facility by the child's parent, foster parent or legal guardian in the original dispensing container which specifies administration instructions, except when a verbal order is obtained from the attending physician and the medication is delivered to the facility by a pharmacy. In such a case, the facility shall provide the container with the new medication to the child's parent, foster parent or legal guardian the same day the medication was delivered to the facility. Administered only upon written and signed orders of the child's attending physician.

(2) All physician orders shall be current and maintained in the child's medical record at the facility. Verbal orders from the attending physician for services to be rendered at the facility may be received and recorded by licensed nursing personnel in the child's medical record at the facility and shall be signed by the attending physician within thirty (30) working days.

(3) Administered by facility personnel acting within the scope of their practice.

(j) Nutrition services, as required by paragraph (b) of this section, shall include a minimum of one meal per day, between meal nourishment, and consultation services by the facility's dietitian. Therapeutic diets, as defined in Title 22, Section 72115, and between meal nourishment shall be provided and served as prescribed by the attending physician. The child's parent, foster parent or legal guardian shall supply the facility with baby food, baby formula, enteral formula, and any other food or snack items not included in the facility's fixed meal menu. The administration of all food shall be supervised by licensed or certified personnel functioning within their scope of practice and documented in the plan of treatment.

(k) Each pediatric day health care facility shall provide readily available emergency health services as follows:

(1) The facility shall obtain a written agreement from the child's parent, foster parent or legal guardian granting the facility permission to transfer the child to a hospital or other health facility in case of an emergency.

(2) The facility shall maintain written agreements for the provision of emergency medical care which shall include:

(A) An on-call physician.

(B) Hospital or emergency room care.

(C) Medical transportation.

(3) First aid services shall be available at the facility. All personnel shall receive in-service training in first aid. Training in cardiopulmonary resuscitation shall be in accordance with Sections 51242.1(d)(5)(A) and (B).

s 51243. Intermediate Care Facility for the Developmentally Disabled.

An intermediate care facility for the developmentally disabled as defined in Section 51164 shall meet each of the following requirements:

(a) Be licensed by the Department of Health Services as any of the following:

(1) A hospital pursuant to the provisions of Sections 70101 through 70137 of Title 22 of the California Administrative Code.

(2) A psychiatric hospital pursuant to the provisions of Sections 71101 through 71135 of Title 22 of the California Administrative Code.

(3) A skilled nursing facility pursuant to the provisions of Sections 72201 through 72241 of Title 22 of the California Administrative Code.

(4) An intermediate care facility pursuant to the provisions of Sections 73201 through 73241 of Title 22 of the California Administrative Code.

(b) Meet the standards and be certified to participate in the Medi-Cal program under:

(1) Section 51215, Skilled Nursing Facility.

(2) Section 51212, Intermediate Care Facility.

(3) Section 51207, Hospitals.

(c) Be certified by the department as meeting the standards specified in 42 Code of Federal Regulations, Sections 442.400 through 442.516 and applicable standards in Sections 442.250 through 442.254 or be provisionally certified as meeting these standards with a federal or state approved plan of correction.

(d) Be licensed and approved to provide intermediate care facility services to the developmentally disabled pursuant to the provisions of Sections 76000 through 76725 of Title 22 of the California Administrative Code.

s 51243.1. Intermediate Care Facility for the Developmentally Disabled Habilitative.

(a) An intermediate care facility for the developmentally disabled habilitative as defined in Section 51164.1 shall:

(1) Be licensed by the Department as an intermediate care facility for the developmentally disabled habilitative pursuant to the provisions of Sections 76800 through 76962 of Title 22 of the California Administrative Code.

(2) Be certified by the Department as meeting the standards and conditions specified in Title 42, Code of Federal Regulations, Sections 440.150, 442.100 through 442.115, and 442.400 through 442.516.

(b) Each facility shall cooperate with the State Medical Review Team and keep on file the following items:

(1) A description of procedures to be used for taking needed corrective action following a state review.

(2) Records and reports sent to the facility by the State Medical Review Team.

s 51243.2. Intermediate Care Facility for the Developmentally Disabled-Nursing.

(a) An intermediate care facility for the developmentally disabled-nursing as defined in Section 51164.2 shall:

(1) Be licensed by the Department as an intermediate care facility for the developmentally disabled-nursing pursuant to the provisions of Sections 73846 through 73855, Title 22, California Code of Regulations.

(2) Be certified by the Department as meeting the applicable standards and conditions specified in Title 42, Code of Federal Regulations, Sections 440.150, 442.100 through 442.112 and Part 483, Support D.

(b) Each facility shall cooperate with the State Medi-Cal Utilization Review Team and keep on file the following items:

(1) Policies and procedures to be used for taking needed corrective action of identified deficiencies following a state review.

(2) Records and reports sent to the facility by the State Medi-Cal Utilization Review Team.

s 51244. In-Home Medical Care Waiver Services Provider and Nursing Facility Waiver Services Provider.

(a) An in-home medical care waiver services provider and a nursing facility waiver services provider shall:

(1) Be licensed in accordance with appropriate state or local laws; and

(2) Be certified in accordance with the standards set forth in the applicable federal waiver and in a written agreement between the Department and the provider of services

necessary to implement the in-home medical care waiver services program component or the Nursing Facility Waiver Services program component. In the event the specific standards for participation are not set forth in the waiver and agreement and the services to be provided are the same as otherwise set forth in Article 2 of this chapter (excluding Section 51173.1 and Section 51176), the provider shall adhere to the provider standards applicable to the service to be provided, as otherwise set forth in Article 3 of this chapter, commencing with Section 51200; and

(3) Be certified to participate in the Medi-Cal program by meeting the standards for participation as a provider under the Medi-Cal program, being in compliance, where applicable, with the Medicare and Medicaid requirements of Titles XVIII and XIX of the Social Security Act.

s 51245. Nurse Midwife.

A nurse midwife shall be licensed as a registered nurse and currently certified as a nurse midwife by the California Board of Registered Nursing.

s 51246. Home and Community-Based Waiver Services Providers.

(a) A home and community-based waiver services provider shall:

(1) Be licensed in accordance with the appropriate state laws; and

(2) Be certified in accordance with the standards set forth in the applicable federal waiver approved by the Department of Health and Human Services; or

(3) In the event specific standards for participation are not set forth in the waiver and the services to be provided are the same as otherwise set forth in Article 2 of this chapter (excluding Section 51176) as a Medi-Cal covered benefit in the absence of a waiver, the provider shall adhere to the provider standards applicable to the service to be provided, as otherwise set forth in Article 3 of this chapter, commencing with Section 51200.

s 51247. Swing Bed Facility.

(a) Swing bed facilities as defined in Section 51178 shall:

(1) Meet the standards for hospitals specified in Section 51207.

(2) Be certified as a special hospital provider of long-term services under Title XVIII of the Federal Social Security Act.

(3) Be approved by the Department as a primary health service hospital in accordance with Division 2, Article 10 of the Health and Safety Code commencing with Section 1339.

s 51248. Ocularist.

An ocularist shall be certified by the American Anaplastology Association, or by the National Examining Board of Ocularists, or shall be a graduate of at least a two year course in ocular prostheses sponsored by a school or college of medicine or optometry, and whose degrees are accepted by the applicable board, or shall be a California licensed physician and surgeon, optometrist, or optician.

s 51249. Application Process for Comprehensive Perinatal Providers.

(a) Except where a capitated health system contract entered into by the Department provides otherwise, to become a comprehensive perinatal provider as defined in Section 51179.1, the Medi-Cal enrolled provider shall complete and submit a Department approved application form entitled Application for Certification As A Comprehensive Perinatal Provider Under Medi-Cal to the local health department or designated State agent for review. The designated agent may include counties or other non-profit organizations as designated by the Director of the Department. Applications shall be available from the local Comprehensive Perinatal Services Program Coordinator or the State Maternal and Child Health Branch, 714 P Street, Sacramento, CA 95814.

(b) The Department shall utilize the following criteria in evaluating applications:

(1) Provider's ability to provide the services specified in Section 51348 through the provider's own service or through subcontractors.

(2) Training and experience of providers rendering services specified in Section 51348.

(3) Quality of care rendered by providers as evidenced by history of:

(A) Revocations, suspensions, or restrictions by a licensing authority.

(B) The extent of training received in the provision of comprehensive perinatal care which has been approved by the State.

(c) The Department shall have responsibility for the final decision and for notifying the provider of acceptance or rejection of the application.

(d) The Department shall:

(1) Within 60 calendar days from receipt of the application, inform the applicant in writing that the application is complete and acceptable or that the application is deficient and what specific information or clarification is necessary.

(2) Within 60 calendar days from receipt of an application which is complete upon initial submission, reach a decision to approve or deny the applicant for participation as a comprehensive perinatal provider.

(3) Within 60 calendar days from receipt of any information or clarification necessary to make an application complete, reach a decision to approve or deny the applicant for participation as a comprehensive perinatal provider.

(4) Send written notification to the applicant upon approval or denial for participation as a comprehensive perinatal provider. The written notification of the denial shall contain the basis for the denial.

(e) An applicant whose application has been denied shall have 30 calendar days from the date of the receipt of written notification of the denial to submit a written appeal to the Department. This written appeal shall contain factual statements as to why the applicant meets the criteria which have been cited as the basis for the denial of the application. The Department shall issue a written decision within 60 calendar days of receipt of the applicant's appeal.

s 51250. Hospice.

A hospice shall:

(a) Be certified and continue to meet the conditions for participation as a hospice under Title XVIII of the Social Security Act, Section 1861 (dd), (42 U.S.C. 1395x(dd)).

(b) Make available and provide core services and other services, and utilize volunteers as specified in 42 Code of Federal Regulations, Part 418, Subpart C, in accordance with the conditions specified. Reference to Medicare beneficiaries shall apply equally to Medi-Cal beneficiaries.

(c) Not discontinue or diminish care provided to a Medi-Cal beneficiary based on expiration of the beneficiary's final election period.

(d) Make available to the Department complete, accurate medical and fiscal records, signed and dated by appropriate staff, to fully substantiate all claims for hospice services submitted to the Department, and shall permit access to all records and facilities for the purpose of claims audit, program monitoring and utilization review.

(e) Notify the Department of Health Services by mail postmarked within two working days of approval of hospice benefits for an individual by a Medi-Cal Consultant.

s 51251. Medical Device Retailer.

Any Medi-Cal provider who dispenses dangerous medical devices, as defined in Business and Professions Code section 4034.5, shall have a valid pharmacy license or medical device retailer permit issued by the Board of Pharmacy pursuant to Business and Professions Code section 4034.5 and 4081.

s 51255. Licensed Midwife.

(a) In order to participate in the Medi-Cal Program, a licensed midwife shall enroll as a Medi-Cal Provider, pursuant to Article 1 of Chapter 3 commencing with Section 51000.

(b) A licensed midwife shall comply with the provisions of the Licensed Midwifery Practice Act of 1993, as set forth in Business and Professions Code Section 2505 et seq.

(c) A licensed midwife shall be supervised by a licensed physician and surgeon who has current practice or training in obstetrics and who shall:

(1) Have current, unrevoked, unsuspended hospital privileges in obstetrics;

(2) Be a current Medi-Cal provider; and

(3) Supervise no more than four individual licensed midwives at once, so as not to exceed a ratio of four individual licensed midwives to one individual supervising licensed physician and surgeon.

(d) The supervision required in (c) of this section shall not be construed to require the physical presence of the supervising licensed physician and surgeon.

s 51260. Certified Nurse Practitioner.

A Certified Nurse Practitioner shall meet the standards prescribed by the Board of Registered Nursing within the State of California.

s 51270. Local Educational Agency (LEA) Provider.

(a) A Local Educational Agency (LEA) Provider, as defined in Section 51190.2, shall be certified by the Department of Education as meeting all of the following conditions for participation:

(1) The LEA Provider meets the definition of an LEA as stated in Education Code, Section 33509(e), and

(2) The LEA Provider has signed a contract with the Department of Health Services.

(b) As a condition for participation, LEA Providers shall comply with the following requirements:

(1) Any federal funds received by an LEA Provider for LEA Services shall be reinvested by the LEA Provider in services, as identified in Education Code Section 8804(g), for school children and their families,

(2) LEA Providers shall consult with a local school-linked services collaborative group, such as defined in Education Code, Section 8806, regarding decisions on reinvestment of federal funds referred to in (b)(1) above,

(3) LEA Providers shall submit annually, on or before October 10th, a certification of the specific amount available in non-federal matchable funds to draw down federal Medicaid funds for the specific fiscal year.

(4) LEA Providers shall adhere to and comply with all federal and state third party liability requirements prior to billing Medi-Cal, including but not limited to policy directives issued by the federal Department of Health and Human Services and Health Care Financing Administration and those standards found in 42 United State Code Section 1396a(a)(25); 42 Code of Federal Regulations Section 433.139; Welfare and Institutions Code, Sections 14005, 14023.7, 14124.90; and Title 22, California Code of Regulations, section 51005 and Article 15 commencing with Section 50761.

(5) LEA Providers shall comply with confidentiality requirements as specified in 42 United States Code Section 1320c-9; 42 Code of Federal Regulations, Section 431.300; Welfare and Institutions Code, Section 14100.2; California Code of Regulations, Title 22, Section 51009; and Education Code, Sections 49060 and 49073 through 49079.

(6) LEA Providers shall submit an Annual Report which shall include, but is not limited to, the following:

(A) Identification of who participates in the community collaborative;

(B) Concise summary financial statement identifying funds received as a result of claiming for LEA Services and identifying both, how funds will be reinvested and how funds were reinvested in the previous year; and

(C) Identification of anticipated services priorities for the future.

(c) LEA Providers shall maintain records as necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary.

(d) LEA Providers shall maintain records showing that all LEA Practitioners, which it employs or with which it contracts, meet and shall continue to meet all appropriate licensing and certification requirements.

(e) LEA Providers shall review each publication of the "suspended and ineligible list" of Medi-Cal providers periodically published and distributed by the Department. LEA Providers may not bill for services rendered by any practitioners found on this list during the suspended or ineligible period.

(f) LEA Providers shall adhere to and comply with all federal Health and Human Services and Health Care Financing Administration requirements with respect to billing for services provided by other health care professionals under contract with the LEA.

(g) The LEA Provider shall ensure that its practitioners provide only those services which are within their appropriate scope of practice.

s 51271. Targeted Case Management Services Provider Qualifications.

(a) A targeted case management provider of services shall be a local governmental agency and shall:

(1) Contract with the department to provide targeted case management services as a condition of enrollment as a targeted case management provider in the Medi-Cal program, and

(2) Provide and certify the non-federal match, and

(3) Have an established fee mechanism effective January 1, 1995, specific to targeted case management services provided, which may include a sliding fee schedule based on income and vary by program, and

(4) Have an established procedure for performance monitoring that assures the participating units are complying with state and federal requirements, and

(5) Make available to the department a performance monitoring plan, including protocols and procedures, establishing a countywide system to assure non-duplication of services and to ensure coordination and continuity of care among providers of targeted case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

(6) Have an administrative capacity to ensure quality of services in accordance with state and federal requirements.

(7) Have a financial management capacity and system that provides documentation of services and costs.

(8) Have a capacity to document and maintain individual case records in accordance with state and federal requirements.

(9) Have a demonstrated ability to meet all requirements of state and federal law governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

(10) Have a minimum of five years of experience in providing case management services to the target population.

(b) In addition to the requirements specified in subsection (a), targeted case management service providers shall meet the following supplemental requirements:

(1) For the purpose of providing targeted case management services to high-risk persons identified in Section 51185(b) the targeted case management services provider shall:

(A) Designate a public health agency employing staff with case manager qualifications as specified in Section 51272.

(B) Have the ability to evaluate the effectiveness, accessibility and quality of targeted case management services on a community-wide basis.

(C) Have established referral systems and demonstrated linkages and referral ability with essential social and health services agencies.

(2) For the purpose of providing service to the target population specified in Section 50262.7(a)(2) the targeted case management services provider shall:

(A) Designate a public health agency employing staff with case manager qualifications as specified in Section 51272.

(B) Ensure 24-hour availability of case management services and continuity of those services.

(C) Have the capacity to communicate with persons who have little or no proficiency in the English language.

(3) For the purpose of providing service to the target population specified in Section 50262.7(a)(3)(A) the targeted case management services provider shall:

(A) Ensure 24-hour availability of case management services and continuity of those services.

(B) Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies.

(4) For the purpose of providing service to the target population specified in Section 50262.7(a)(3)(B), (C) or (D), the targeted case management services provider shall:

(A) Designate an agency employing staff with case manager qualifications as specified in Section 51272.

(B) Ensure 24-hour availability of case management services and continuity of those services.

(C) Have established referral systems and demonstrated linkages and referral ability with essential social and health services agencies.

(5) For the purpose of providing service to the target population specified in Section 50262.7(a)(3)(E) the targeted case management services provider shall:

(A) Demonstrate programmatic and administrative experience in providing services which prevent institutionalization and have the ability to increase their service capability to provide services to adults of all ages.

(B) Demonstrate they have an advisory group which includes representatives of the target group.

(C) Have established referral systems and demonstrated linkages and referral ability with essential social and health services agencies.

(c) A local education agency may not enroll as a targeted case management services provider.

(d) To qualify as a provider of targeted case management services, local governmental agencies shall:

(1) Notify the department in writing of the intent to claim targeted case management for a specific targeted group. Such notice shall be received by the department no later than September 1 of each year, and

(2) Demonstrate participation in a time survey as scheduled by the department, and

s 51272. Targeted Case Manager.

(a) Case managers employed by a targeted case management services provider shall meet the following minimum requirements for education, training and experience:

(1) For the targeted population specified in Section 51185(b), be certified as a Public Health Nurse or a Registered Nurse, or a Licensed Vocational Nurse under the direct supervision of a skilled professional medical person, or an individual who possesses the education and/or experience specified in (3) below and who is under the direct supervision of a skilled professional medical person.

(2) For the targeted populations specified in Sections 50262.7(a)(2), and 50262.7(a)(3)(E), be a Registered Nurse; or possess the education and/or experience specified in subsection (a)(3) below, under the direct supervision of a skilled professional medical person.

(3) For the target populations specified in Sections 50262.7(a)(3)(A), (B), (C) and (D), have education or relevant case management experience consisting of a Bachelor's degree in a health or human services field; an Associate of Arts degree with two years experience performing case management duties in a health and human services field; or four years experience performing case management duties in a health or human services field.

(4) All individuals providing case management services pursuant to this section, except Public Health Nurses and Registered Nurses, shall have completed agency-approved case management training.

(b) Targeted case management case managers shall not perform contract management, program planning and policy development, coordination of targeted case management data systems and claiming, and targeted case management quality assurance and/or performance monitoring.

s 51273. Targeted Case Management Advisory Committee.

s 51276. Directly Observed Therapy (DOT) Provider Qualifications.

(a) Each provider of Directly Observed Therapy (DOT) shall:

(1) Have a manager responsible for the tuberculosis (TB) DOT program who supervises and monitors DOT staff activities and ensures appropriate documentation of TB patient records.

(2) Ensure all staff providing DOT have provider-approved DOT training.

(3) Have policies and protocols for the provision of DOT to ensure the following:

(A) Assessment of individual barriers to DOT, such as a TB patient's need for transportation.

(B) Appropriate selection of either field-based or clinic-based DOT based upon potential patient barriers to completion of DOT.

1. Field-based DOT means DOT provided to a TB patient at his/her place of residence, work site, shelter, or any other location agreed upon between DOT staff and the TB patient.

2. Clinic-based DOT means DOT provided to a TB patient at the site of the provider agency.

(C) Patients receive and ingest the prescribed medications and insuring renewals of and/or changes to medications are promptly obtained.

(D) Patient ingestion of medications is recorded in the patient's case record.

(E) Documentation in patient case files include all activities related to the provision of DOT.

(F) Reporting to both the local health department and the treating physician when there is failure to make contact with a TB patient at any time during the course of treatment.

(G) Reporting to the treating physician all side effects or other patient problems.

(H) Confidentiality of patient records.

(4) Have the capacity to provide TB DOT in a manner that is linguistically and culturally appropriate to the population being served.

(5) Initiate active outreach to locate a patient after a patient's missed appointment with DOT staff. Active outreach shall include, but is not limited to, the following:

(A) Reviewing patient information and evaluating locating information.

(B) Developing a strategy for locating the patient.

(C) Promptly dispatching DOT staff to physically search for the patient at the last known place of residence, work site, shelter, or other location. DOT staff shall attempt to locate the patient on at least three separate occasions.

s 51301. Schedule of Benefits.

The benefits covered by Medi-Cal are limited to those set forth in this article and in Chapter 5, Article 4.

s 51303. General Provisions.

(a) Health care services set forth in this article and in Chapter 5, Article 4 (commencing with Section 54301 of this title), 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 are covered by the Medi-Cal program, subject to utilization controls, to the extent specified in this Chapter, Chapter 5, and Chapter 11. Such utilization controls shall take into account those diseases, illnesses, or injuries which require preventive health services or treatment to prevent serious deterioration of health. Nothing in this section shall preclude payment for family planning services, or for early, periodic screening, diagnosis and treatment services (EPSDT), provided under the Child Health and Disability Prevention (CHDP) Program.

Authorization may only be granted when fully documented medical justification is provided that the services are medically necessary. Services not requiring prior authorization are subject to other utilization controls, as specified in this chapter.

(b) Limitations specified in this article do not apply to Medicare/Medi-Cal program covered services (crossover services).

(c) Except as set forth in (b) above, if the Medi-Cal Program is to pay any portion of a charge for services for which other coverage is available, the limitations and controls specified in this article apply.

(d) Inpatient services in hospitals are covered only when provided on the signed order of the physician, dentist or podiatrist responsible for the care of the patient.

(e) Inpatient services in skilled nursing facilities and intermediate care facilities are covered only when provided on the signed order of the physician responsible for the care of the patient.

(f) Outpatient services are covered subject to the limitations and controls set forth in this chapter.

(g) Experimental services are not covered.

(h) Investigational services are not covered except when it is clearly documented that all of the following apply:

(1) Conventional therapy will not adequately treat the intended patient's condition;

(2) Conventional therapy will not prevent progressive disability or premature death;

(3) The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service;

(4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;

(5) The service is not being performed as a part of a research study protocol;

(6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.

All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the above criteria, or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such nonapproved investigational services.

(i) Services and supplies not primarily medical in purpose or which are common household items are not covered.

(j) Services set forth in this article must be provided by providers who meet, where applicable, the standards set forth in Article 3 of this chapter.

(k) Services prescribed or ordered by a provider suspended from participation in the Medi-Cal program shall not be covered by the program while the suspension is in effect, providing that at least 15 days written notice is given to all affected providers.

s 51304. Benefit Limitations.

(a) Program coverage of services specified in Sections 51308, 51308.5, 51309, 51310, 51312, and 51331(a)(3) through (9), unless noted otherwise, is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.

(b) For purposes of this section, "services" means all care, treatment, or procedures provided a beneficiary by an individual practitioner on one occasion.

s 51305. Physician Services.

(a) Outpatient physician services are covered if they are medically necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, subject to the limitations specified below.

(b) Outpatient surgical procedures, other than those needed for diagnostic purposes or those rendered as emergency services pursuant to Section 51056; procedures considered to be elective; and specified outpatient medical procedures, including but not limited to,

Hyperbaric Oxygen Therapy, Pheresis, Psoriasis Day Care and Cardiac Catheterization, require prior authorization. Authorization may be granted only when fully documented medical justification is provided that the services are medically necessary. Services not requiring prior authorization are subject to other utilization controls, as specified in this chapter. Utilization controls shall be imposed on medical/surgical procedures in accordance with the standards set forth in Section 51159. Identification of those procedures requiring prior authorization shall be transmitted to all affected providers of service in bulletins authorized by the Department.

(c) Surgical procedures typically performed on an inpatient basis which can be performed safely on an outpatient or ambulatory basis will not be reimbursed in an inpatient setting. Exceptions may be authorized by a field office medical consultant if there is adequate documentation of the medical need for inpatient care. In selecting procedures which should normally be performed in an outpatient setting, the Department shall consider patient safety, quality of medical care, common practice in the medical community, and cost of the procedure. Lists of surgical procedures identified by the Department for performance on an outpatient or ambulatory basis will be transmitted to all interested providers of service in bulletins authorized by the Department.

(d) A maximum of eight psychiatry services and eight injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies may be provided in any 120-day period without prior authorization. Prior authorization shall be required when more than eight psychiatry or eight of the above allergy injections are provided in a 120-day period except those provided on an emergency basis.

(1) Services rendered on an emergency basis are exempt from authorization. The emergency services shall meet the definition in Section 51056 and the provider shall comply with the requirements of that section.

(2) A total treatment plan shall be developed for psychiatry and allergy services which require prior authorization. The treatment plan may be authorized for a period up to 120 days and shall include the following:

(A) The principal diagnosis and significant associated diagnosis.

(B) Clinical information adequate to describe the physiological and functional limitations, including the date of onset of the illness(es).

(C) Prognosis.

(D) Specific services to be rendered.

(E) The therapeutic goals to be achieved and the anticipated time needed to attain those goals.

(F) Drug regimen.

(e) Physician services provided to hospital, skilled nursing facility or intermediate care facility inpatients are covered only during periods of hospital, skilled nursing facility or intermediate care facility stays covered by the program.

(f) Psychiatry, psychology, physical therapy, occupational therapy, audiology, speech therapy, optometry and podiatry services are not covered as physicians' services when performed by persons other than physicians.

(g) Respiratory care is covered as a physician service. Respiratory care is subject to prior authorization except when personally rendered by the physician. Authorization requests shall include clinical justification for the services and the nature, frequency and expected duration of the respiratory care.

(h) Orthoptics and pleoptics are not covered.

(i) Procedures for the treatment of defects for cosmetic purposes only are covered subject to prior authorization. Authorization may be granted only for the correction of serious disfigurement eligible for coverage by California Children Services. These patients shall be referred to that program as provided in Section 51013.

(j) A second eye examination with refraction within twenty-four months is covered only when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date of any prior eye examination with refraction.

(k) Primary care physician services rendered by nonphysician medical practitioners are covered as physician's services to the extent permitted by applicable professional licensing statutes and regulations, and as set forth in the Physician-Practitioner Interface as described in Section 51240.

(l) Services and entries in the patient's health record by non-physician medical practitioners shall be reviewed by the primary care physician within seven calendar days of the date of service.

(2) Patients shall be informed or notified in writing, prior to being served, that medical services may be rendered by nonphysician medical practitioners. In cases of emergencies as defined in Section 51056, the nonphysician medical practitioner may render emergency services to a patient without such prior notification.

(3) Reimbursement for services rendered by nonphysician medical practitioners shall be made in accordance with Section 51503.1.

(4) Reimbursement shall not be made for service rendered by a nonphysician medical practitioner to a person eligible for Medicare benefits unless Medicare makes reimbursement for that service by that practitioner.

(5) Out-of-State services of nonphysician medical practitioners are covered in accordance with each of the following:

(A) The Medicaid law and program for that location.

(B) Local laws applicable to such practitioners.

(C) The provisions of Section 51006.

(1) External mammary prostheses made of silicone or other similar materials, prosthetic mammary implants, and reconstructive mammoplasty shall be deemed medically necessary incident to mastectomy and shall be covered. "Mastectomy" means the surgical procedures as described in the latest edition of the Physicians' Current Procedural Terminology for the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon who is a Department Medi-Cal consultant.

(m) One early discharge follow up visit is covered without prior authorization when the requirements of Section 51327(b) are met.

s 51305. Physician Services.

(a) Outpatient physician services are covered if they are medically necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, subject to the limitations specified below.

(b) Outpatient surgical procedures, other than those needed for diagnostic purposes or those rendered as emergency services pursuant to Section 51056; procedures considered to be elective; and specified outpatient medical procedures, including but not limited to, Hyperbaric Oxygen Therapy, Pheresis, Psoriasis Day Care and Cardiac Catheterization, require prior authorization. Authorization may be granted only when fully documented medical justification is provided that the services are medically necessary. Services not requiring prior authorization are subject to other utilization controls, as specified in this chapter. Utilization controls shall be imposed on medical/surgical procedures in accordance with the standards set forth in Section 51159. Identification of those procedures requiring prior authorization shall be transmitted to all affected providers of service in bulletins authorized by the Department.

(c) Surgical procedures typically performed on an inpatient basis which can be performed safely on an outpatient or ambulatory basis will not be reimbursed in an inpatient setting. Exceptions may be authorized by a field office medical consultant if there is adequate documentation of the medical need for inpatient care. In selecting procedures which should normally be performed in an outpatient setting, the Department shall consider patient safety, quality of medical care, common practice in the medical community, and cost of the procedure. Lists of surgical procedures identified by the Department for performance on an outpatient or ambulatory basis will be transmitted to all interested providers of service in bulletins authorized by the Department.

(d) A maximum of eight psychiatry services and eight injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies may be provided in any 120-day period without prior authorization. Prior authorization shall be required when more than eight psychiatry or eight of the above allergy injections are provided in a 120-day period except those provided on an emergency basis.

(1) Services rendered on an emergency basis are exempt from authorization. The emergency services shall meet the definition in Section 51056 and the provider shall comply with the requirements of that section.

(2) A total treatment plan shall be developed for psychiatry and allergy services which require prior authorization. The treatment plan may be authorized for a period up to 120 days and shall include the following:

(A) The principal diagnosis and significant associated diagnosis.

(B) Clinical information adequate to describe the physiological and functional limitations, including the date of onset of the illness(es).

(C) Prognosis.

(D) Specific services to be rendered.

(E) The therapeutic goals to be achieved and the anticipated time needed to attain those goals.

(F) Drug regimen.

(e) Physician services provided to hospital, skilled nursing facility or intermediate care facility inpatients are covered only during periods of hospital, skilled nursing facility or intermediate care facility stays covered by the program.

(f) Psychiatry, psychology, physical therapy, occupational therapy, audiology, speech therapy, optometry and podiatry services are not covered as physicians' services when performed by persons other than physicians.

(g) Respiratory care is covered as a physician service. Respiratory care is subject to prior authorization except when personally rendered by the physician. Authorization requests shall include clinical justification for the services and the nature, frequency and expected duration of the respiratory care.

(h) Orthoptics and pleoptics are not covered.

(i) Procedures for the treatment of defects for cosmetic purposes only are covered subject to prior authorization. Authorization may be granted only for the correction of serious disfigurement eligible for coverage by California Children Services. These patients shall be referred to that program as provided in Section 51013.

(j) A second eye examination with refraction within twenty-four months is covered only when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date of any prior eye examination with refraction.

(k) Primary care physician services rendered by nonphysician medical practitioners are covered as physician's services to the extent permitted by applicable professional

licensing statutes and regulations, and as set forth in the Physician-Practitioner Interface as described in Section 51240.

(1) Services and entries in the patient's health record by non-physician medical practitioners shall be reviewed by the primary care physician within seven calendar days of the date of service.

(2) Patients shall be informed or notified in writing, prior to being served, that medical services may be rendered by nonphysician medical practitioners. In cases of emergencies as defined in Section 51056, the nonphysician medical practitioner may render emergency services to a patient without such prior notification.

(3) Reimbursement for services rendered by nonphysician medical practitioners shall be made in accordance with Section 51503.1.

(4) Reimbursement shall not be made for service rendered by a nonphysician medical practitioner to a person eligible for Medicare benefits unless Medicare makes reimbursement for that service by that practitioner.

(5) Out-of-State services of nonphysician medical practitioners are covered in accordance with each of the following:

(A) The Medicaid law and program for that location.

(B) Local laws applicable to such practitioners.

(C) The provisions of Section 51006.

(1) External mammary prostheses made of silicone or other similar materials, prosthetic mammary implants, and reconstructive mammoplasty shall be deemed medically necessary incident to mastectomy and shall be covered. "Mastectomy" means the surgical procedures as described in the latest edition of the Physicians' Current Procedural Terminology for the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon who is a Department Medi-Cal consultant.

(m) One early discharge follow up visit is covered without prior authorization when the requirements of Section 51327(b) are met.

s 51305.2. Requirements for Sterilization Other Than Emergency Sterilization.

s 51305.2. Requirements for Sterilization Other Than Emergency Sterilization.

s 51305.4. Certification of Informed Consent for Sterilization.

(a) The Consent Form, provided by the Department in English and Spanish, shall be the only approved form and shall be signed and dated by the:

(1) Individual to be sterilized.

(2) Interpreter, if one is provided.

(3) Person who obtained the consent.

(4) Physician who performed the sterilization procedure.

(b) The person securing consent shall certify, by signing the Consent Form, to have personally:

(1) Advised the individual to be sterilized, before the individual to be sterilized signed the Consent Form, that no federal benefits may be withdrawn because of the decision not to be sterilized.

(2) Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the Consent Form and in Section 51305.3.

(3) Determined, to the best of his or her knowledge and belief, that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

(c) The physician performing the sterilization shall certify, by signing the Consent Form, that:

(1) The physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized.

(2) The physician explained orally the requirements for informed consent as set forth on the Consent Form.

(3) To the best of the physician's knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

(4) At least 30 days have passed between the date of the individual's signature on the Consent Form and the date upon which the sterilization was performed, except in the following instances:

(A) Sterilization may be performed at the time of emergency abdominal surgery if the physician:

1. Certifies that the written informed consent to be sterilized was given at least 30 days before the individual intended to be sterilized.

2. Certifies that at least 72 hours have passed after written informed consent to be sterilized was given.

3. Describes the emergency on the Consent Form.

(B) Sterilization may be performed at the time of premature delivery if the physician certifies that:

1. The written informed consent was given at least 30 days before the expected date of the delivery. The physician shall state the expected date of delivery on the Consent Form.

2. At least 72 hours have passed after written informed consent to be sterilized was given.

(d) The interpreter, if one is provided, shall certify that the interpreter:

(1) Transmitted the information and advice presented orally to the individual to be sterilized.

(2) Read the Consent Form and explained its contents to the individual to be sterilized.

(3) Determined, to the best of the interpreter's knowledge and belief, that the individual to be sterilized understood what the interpreter told the individual.

(e) The person who obtains consent shall provide the individual to be sterilized with a copy of the booklet on sterilization, provided by the Department in English and Spanish, before obtaining consent.

(f) For the purposes of this section, shortly before means a period within 72 hours prior to the time the patient receives any preoperative medication.

s 51305.5. Additional Requirements for Informed Consent Process for Elective Sterilization.

s 51305.6. Hysterectomy.

(a) A hysterectomy shall not be covered if:

(1) Performed solely for the purpose of rendering an individual permanently sterile.

(2) There is more than one purpose to the procedure, and the hysterectomy would not be performed except for the purpose of rendering the individual permanently sterile.

(b) Except for previously sterile women, a nonemergency hysterectomy may be covered only if:

(1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile.

(2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in (1).

(3) The individual has been informed of the rights to consultation by a second physician.

(c) A copy of the signed statement shall be:

(1) Provided to the patient.

(2) Retained by the physician and the hospital in the patient's medical records.

(3) Attached to the physician's billing form.

(d) For previously sterile women, hysterectomy may be covered if the physician certifies the individual was previously sterile and states the cause of sterility on the claim form or an attachment.

(e) An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.

s 51305.7. Noncompliance.

(a) Noncompliance with Sections 51305.1 through 51305.6 shall result in nonpayment for sterilization services.

(b) Noncompliance with Sections 51305.1 through 51305.6 shall result in a referral to the Board of Medical Quality Assurance.

s 51305.8. Effective Date.

s 51305.9. Interim Coverage of Intermediate and Comprehensive Ophthalmological Services for Nonaphakic Beneficiaries.

s 51306. Optometry Services.

(a) Services provided by optometrists acting within the scope of their practice as authorized by California law are covered, except as otherwise limited by these regulations.

(b) Orthoptics and pleoptics are not covered.

(c) A second eye examination with refraction within twenty-four months is covered only when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date of any prior eye examination with refraction.

s 51306.1. Interim Coverage of Optometric Services for Nonaphakic Beneficiaries over 21.

s 51306.1. Interim Coverage of Optometric Services for Nonaphakic Beneficiaries over 21.

s 51307. Dental Services.

(a) Outpatient and inpatient dental services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury or defect are covered to the extent specified in this section.

(b) The following services are covered without prior authorization when need is justified and documented, subject to postservice audit by review of appropriate diagnostic material.

(1) Emergency dental services which conform to the definitions in section 51056.

(2) Diagnostic services, including examination, radiographs, biopsy and dental prophylaxis necessary to develop a treatment plan.

(A) Examinations, are covered as follows:

1. Procedure 9010, initial examination, is covered once per beneficiary per dentist for the initial comprehensive history, diagnosis and treatment plan.

2. Procedure 9015, periodic examination, is covered once each subsequent 12-month period, after 12 months have elapsed following provision of procedure 9010, for an established patient receiving intermediary care facility services for the developmentally disabled.

(B) Radiographs, shall be taken in compliance with all applicable state and federal regulations for radiation hygiene as follows:

1. Single radiographs are covered to a maximum of 11 radiographs.

2. Full mouth radiographs are covered once in a 36 month period, and shall consist of:

a. 14 periapical radiographs plus bitewings, or

b. panoramic radiograph plus bitewings, or

c. panoramic radiograph plus periapical radiographs.

3. Panoramic radiographs alone when appropriate to the diagnosis in orthodontic care, oral or maxillofacial dental procedures, or extractions in two or more quadrants are covered once in a 36-month period, except when documented as essential for follow-up or postoperative care in a treatment series.

(C) Dental prophylaxis, or dental prophylaxis with topical fluoride application for children through age 17, but not more than once in a 12-month period.

(D) Dental sealants in pits and fissures that are both free of restorations and nonincipient decay in the surface(s) to be sealed for:

1. Permanent first molars in beneficiaries to age twenty-one (21) and;

2. Permanent second molars in beneficiaries to age twenty-one (21).

(3) Dental extractions of symptomatic teeth, and other oral surgical procedures, except those extractions converting a beneficiary to complete or partial edentulism qualifying for covered removable prostheses and maxillofacial dental services as defined under (e)(1).

(4) Injectable therapeutic drugs, relative analgesia where warranted by documented conditions of infection or patient management, and general anesthesia where documented that local anesthetic is contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension or nervousness are not of themselves sufficient justification for relative analgesia or general anesthesia.

(5) Occlusal Adjustment (Per Quadrant).

(6) Gingivectomy/Gingivoplasty Per Quadrant and Osseous Mucogingival Surgery Per Quadrant after Subgingival Curettage and Root Planing has been rendered.

(7) Vital pulpotomy for vital pulps and therapeutic pulpotomy for nonvital primary teeth.

(8) Treatment of dental caries with silver amalgam, silicate cement, acrylic, composite, plastic restorations or stainless steel crowns, except for incipient or nonactive caries in adults.

(9) Cast or preformed posts in endodontically treated teeth only.

(10) Endothermic reline, i.e., chair side, only once in a 12-month period.

(11) Space maintainers where there is sufficient room for an unerupted permanent tooth to erupt normally.

(12) Repairs for existing crowns, bridges and removable dentures.

(13) Reduction of oral and maxillofacial fractures and dislocations.

(c) The Department may require that selected providers obtain prior authorization for all nonemergency and nondiagnostic procedures. The Department shall give written notice to the provider prior to implementation.

(d) The following services are not covered:

(1) Orthodontic services, except in the treatment of handicapping malocclusion for persons under the age of 21 and in the treatment of cleft palate deformities under the case management of California Children Services Program.

(2) Treatment of incipient or nonactive caries in adults.

(3) Cosmetic procedures.

(4) Removable partial dental prostheses, except when necessary for balance of a complete artificial denture.

(5) Extraction of asymptomatic teeth, except for:

(A) Serial extractions required to minimize malocclusion or malalignment.

(B) Teeth that interfere with the construction of a covered dental prosthesis.

(C) Perceptible radiologic pathology that fails to elicit symptoms.

(D) Extractions that are required to complete medically necessary orthodontic dental services.

(6) Experimental procedures.

(7) Procedures, appliances or restorations that:

(A) Increase vertical dimension.

(B) Restore occlusion.

(C) Replace tooth structure lost by attrition.

(D) Are for implantology techniques.

(8) Pulp caps.

(9) Fixed bridges except when necessary for:

(A) Obtaining employment.

(B) Medical conditions which preclude the use of removable dental prostheses.

(e) The following services are covered with prior authorization required when necessity is justified and documented:

(1) Maxillofacial dental services, provided by a dentist listed under Section 51223, as determined by the Department. For the purpose of this section, maxillofacial dental services means anatomic and functional reconstruction of those regions of the mandible and maxillae and associated structures that are missing or defective because of surgical intervention, trauma, pathology, developmental or congenital malformations, and the diagnosis and treatment of temporomandibular joint dysfunction. These procedures may be subject to review by the Department.

(2) Orthodontic services in the treatment of cleft palate deformities when under the case management and authorization of California Children Services Program.

(3) Dental extractions creating complete or partial edentulism in preparation for a covered dental prosthesis.

(4) Periodontal treatment: Subgingival Curettage and Root Planing, per treatment; Occlusal adjustment (minor spot grinding); and Gingivectomy or Gingivoplasty Treatment; Osseous and mucogingival surgery.

(5) Endodontic therapy: Root canal treatment in permanent teeth; Recalcification including temporary restoration; Apicoectomy; and Apexification/Apexogenesis.

(6) Laboratory processed crowns for permanent teeth.

(7) Full dentures, removable partial dentures that are necessary for the balance of a complete artificial denture, stayplates and reconstructions of removable dentures using standard procedures which exclude precision attachments or implants. These services are covered only once in a five-year period by the Medi-Cal program, except when necessary to:

(A) Prevent significant disability.

(B) Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

(8) Fixed bridges necessary for:

(A) Obtaining employment.

(B) Medical conditions which preclude the use of removable dental prostheses.

(9) Tissue conditioning, limited to two tissue conditionings per appliance in a 12-month period, when necessary prior to denture construction, reconstruction or laboratory processed reline.

(10) Laboratory processed reline once in a 12-month period.

(f) Dental services rendered to hospital, skilled nursing or intermediate care facility patients are covered only:

(1) During a period of hospital, skilled nursing or intermediate care facility stay covered by the Medi-Cal program.

(2) When provided pursuant to the signed authorization of the provider responsible for the patient's care and the authorization is documented on the patient's chart.

(3) Following prior authorization of each nonemergency and nondiagnostic dental service.

(g) Effective August 15, 1993, for persons 21 years of age or older, the services specified in subsections (a) through (f) shall be provided subject to program criteria and the following conditions:

(1) Periodontal treatment, as defined in subsection (e)(4), is not a benefit. Emergency periodontal treatment is provided as palliative treatment only.

(2) Endodontic therapy, as defined in subsection (e)(5), is not a benefit, except for vital pulpotomy.

(3) Laboratory processed crowns are not a benefit.

(4) Removable prosthetics shall be a benefit only for patients as a requirement for employment. Employment shall be documented by providing proof that an individual is maintaining and/or actively seeking employment.

(5) Notwithstanding the conditions specified in subsections (g)(1) to (g)(4), inclusive, the department may approve services, subject to utilization controls, which are medically necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

s 51308. Chiropractic Services.

Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation and subject to the limitations set forth in Section 51304(a).

s 51308.5. Acupuncture Services.

(a) Acupuncture services are covered, subject to the limitations set forth below and in Section 51304(a), when provided by one of the following:

(1) A physician, dentist or podiatrist.

(2) An acupuncturist.

(b) Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.

(c) Acupuncture is covered either with or without electric stimulation of the needles.

(d) Acupuncture is covered only when used to treat a condition for which treatment by other modalities is also covered.

s 51309. Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services.

(a) Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements specified in Article 2 and Article 3 of this Chapter.

The written prescription of a physician, dentist or podiatrist is required for physical therapy and occupational therapy services. Speech pathology and audiological services shall be provided only upon the written referral of a physician or dentist.

(b) Physical therapy services shall include physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications. Services do not include the use of Roentgen rays or radioactive materials or the use of electricity for surgical purposes including cauterization. Services are limited to treatment immediately necessary to prevent or to reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.

(c) Occupational therapy services shall include occupational therapy evaluation, treatment planning, treatment, instruction and consultative services.

(d) Such services, except physical therapy, are subject to the limitations set forth in Section 51304(a). Physical therapy services may be provided after prior authorization and approval of a treatment plan is obtained from the Medi-Cal consultant.

(1) The authorization request shall include diagnosis, modalities, frequency, therapeutic goals, duration of treatment and date of progress review where applicable. The physician's, dentist's or podiatrist's prescription shall be attached to the authorization request.

(2) Authorization for physical therapy services shall be contingent upon compliance with the following requirements:

(A) There is direct and specific relationship of the services to written treatment plan prescribed by the physician, dentist or podiatrist after consultation with a qualified physical therapist.

(B) The complexity and sophistication of the level of service or condition of the beneficiary requires the judgment, knowledge and skills of a physical therapist.

(C) Provision of the services is with the expectation that the beneficiary will improve significantly in a reasonable and generally predictable period of time or to establish an effective maintenance program in connection with a specific disease state.

(D) Service is to be performed by a qualified physical therapist who meets the standards set forth in Section 51201.1 of this chapter.

(E) The service is considered, under accepted standards of medical practice, to be a specific and effective treatment for the beneficiary's condition.

(F) The service is reasonable and medically necessary for the treatment of the beneficiary's condition.

(3) Professional physical therapy necessary to establish or periodically reevaluate a palliative or maintenance therapy program may be authorized. Services which do not require the skills of a physical therapist shall not be covered or authorized.

(4) Prior authorization shall not be granted for more than 30 treatments at any one time. Authorizations shall be valid for up to 120 days. A request for reauthorization shall include a statement describing the beneficiary's progress toward achieving the therapeutic goals included in the treatment plan.

s 51309.5. Sign Language Interpreter Services.

(a) Sign language interpreter services, as set forth in Section 51098.5, are covered as part of the Medi-Cal covered physician service subject to the limitation specified in subsection (b). Sign language interpretation services may be utilized for medical services and related services such as, or similar to:

- (1) Obtaining medical history.
- (2) Obtaining informed consent and permission for treatment.
- (3) Explaining diagnoses, treatment and prognoses of an illness.
- (4) Communicating prior to, during or after medical procedures.
- (5) Providing complex instructions regarding medication.
- (6) Explaining instructions for care upon discharge from a medical facility.
- (7) Providing mental health assessment, therapy or counseling.

(b) Reimbursement shall be limited to physicians and physician groups employing fewer than fifteen employees.

(c) Sign language interpreter services shall not be covered for a beneficiary who is receiving services in a health facility that is required by federal regulation 45 Code of Federal Regulations Section 84.52 to provide such services.

s 51310. Podiatry Services.

(a) Services provided by podiatrists, acting within the scope of their practice as authorized by California law, are covered subject to the following:

(1) Podiatric office visits described by procedure codes 99201-99203 and 99211-99213 in the latest edition of the Physicians' Current Procedural Terminology are covered as medically necessary. All other outpatient podiatry services are subject to prior

authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk.

Editorial Note: For full incorporation by reference of the Physicians' Current Procedural Terminology Codes, see CCR, Title 22, section 51050.

(2) Podiatry services rendered on an emergency basis are exempt from prior authorization. Emergency services shall conform to and be in compliance with the provisions of section 51056.

(3) Podiatry services rendered to hospital, skilled nursing facility or intermediate care facility inpatients are covered only when provided pursuant to an order on the patient's chart, signed by the physician or podiatrist who admitted the patient, specifying the care to be given. Services to skilled nursing facility and intermediate care facility inpatients are further subject to prior authorization.

(4) Hospitalization of patients by podiatrists is subject to the procedures set forth in section 51327. Podiatry services provided to hospital inpatients are covered only to the extent that the period of hospitalization is covered by the program.

(b) Routine nail trimming is not covered.