Code Effective
ParaReg Text

585-1

The Two-Plan Model Managed Care Program exists, in the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. (§53800(a))

Each plan in such a designated region shall, in pertinent part:

1. Agree to provide or arrange for the provision of, to the extent allowed by federal and state law, the scope of Medi-Cal program benefits set forth by contract to eligible beneficiaries who select or are assigned to the plan.

2. Provide readily available and accessible health care services and utilize preventive health care programs.

3. Case manage members' utilization of health care services.

4. Inform eligible beneficiaries about nonmedical transportation services that may be available under the Medi-Cal program, including the conditions under which such services will be provided by the plan, and how to request those services which the plan opts to provide.

(§53840(a))

585-2
REVISED
2/14
Enrollment in Two-Plan model plans shall be mandatory for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope;

(2) Have been determined to have a share of cost equal to zero;

(3) Do not meet the criteria for exemption from plan enrollment, specified in section 53887;

(4) Have been determined by their county welfare department to be eligible for one of the following programs:

(A) The section 1931(b) Program, which consists of the services described in Welfare and Institutions Code section 14005.30, including persons whose Medi-Cal eligibility is based upon their receipt of benefits under the California Work Opportunity and Responsibility to Kids (CalWORKS) Program.

(B) The Medically Indigent program for children under age 21, as specified in section 50251(a).

(C) The Medically Needy Program for families and caretaker relatives, specified in sections

50203(a)(2) and (3).

(D) The Other Public Assistance Program as specified in section 50237.

(E) The Special Zero Share of Cost Program for infants, as specified in section 50262; for children of age one to age six, as specified in section 50262.5; and for children of age six to age nineteen, as specified in section 50262.6.

(F) The Transitional Medi-Cal Program as established in accordance with Section 1931 of the federal Social Security Act (Title 42, United States Code, section 1396u-1) and described in Welfare and Institutions Code sections 14005.8 and 14005.81.

(§53845)

585-2A

CDHS or the Health Care Options Program shall mail an enrollment form and plan information to each eligible beneficiary described in §53845(a) who does not attend a health care options presentation. The mailing shall include health care options information and instructions to enroll in a plan within thirty days of the postmark date on the mailing envelope. At a minimum, the mailing shall include instructions on how to enroll, how to request an exemption from mandatory enrollment for medical or nonmedical reasons, and how to request a medical exemption certification form. (§53882(c))

Each eligible beneficiary described in §53845(a) shall select a plan within thirty days of receipt of an enrollment form unless a request for an exemption to plan enrollment is submitted to the Health Care Options Program within 30 days of receipt as prescribed in §53887(b), or within thirty days of the postmark date of the health care options information if mailed.

(1) In the event the eligible beneficiary does not select a plan within thirty days, the Health Care Options Program shall assign the eligible beneficiary to a plan, in accord with §53883.

(§53882(d))

585-2B

State regulations regarding the Two-Plan model provide:

(a) The Health Care Options Program shall assign an eligible beneficiary to a plan within a designated region, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a plan within thirty days of receiving an enrollment form.

(2) In the event a member requests and is granted disenrollment from either plan within that region, but does not enroll in the competing plan, unless that member was granted approval by the department or its designee to receive health care services through the fee-for-service Medi-Cal program.

(3) In the event the competing plan is at capacity, the fee-for-service Medi-Cal option

shall be made available.

(b) In carrying out (a), the Health care Options Program shall comply with the assignment requirements contained in §53884.

(§53883)

585-2C

In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider the Plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the Program. (§53884(b)(3))

585-2D ADDED
8/14
A beneficiary who has not been enrolled in a plan shall remain in fee-for-service Medi-Cal if a request for an exemption from plan enrollment or appeal is submitted, until the final resolution. (W&IC § 14182(a)(21), in pertinent part)

585-2E ADDED
10/15
Any plan member whose Two Plan Managed Care grievance is resolved or unresolved shall have the right to request a fair hearing. Submission of a grievance shall not be construed as a waiver of the member's right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894. (22 CCR §53858(i))

585-3

In Two-Plan Model counties:

(b) Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope.

(2) Have been determined to have an SOC equal to zero.

and

(3) Are eligible for any of the following:

(A) The federal Supplemental Security Income program for the Aged, Blind, and Disabled.

(B) The Medically Indigent program for pregnant women, as specified in §50251(b)(3).

(C) The Foster Care Program as described in W&IC §11400 et seq.

(D) The Adoption Assistance Program as described in W&IC §16115 et seq.

(§53845)

585-4A

In a Two-Plan Model, certain eligible beneficiaries may receive fee-for-service Medi-Cal. State regulations provide that:

An eligible beneficiary meeting the criteria specified in §53845(a), who satisfies the requirements in (1) or (2) below, may request fee for service Medi-Cal for up to 12 months as an alternative to plan enrollment by submitting a request for exemption from plan enrollment to the Health Care Options Program as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in §55100(i), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care.

(A) For purposes of this section, conditions meeting the criteria for a complex medical condition include, and are similar to, the following.

An eligible beneficiary:

1. Is pregnant.

2. Is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately postoperative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

3. Is receiving chronic renal dialysis treatment.

4. Has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

5. Has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

6. Has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately postoperative.

7. Has a complex neurological disorder, such as multiple sclerosis, a complex

hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1. through 6. above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

8. Is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility.

9. Is participating in a pilot project organized and operated pursuant to §§14087.3, 14094.3, or 14490 of the Welfare and Institutions Code.

(§53887(a), effective December 19, 2000)

585-4B

A request for exemption from plan enrollment (in a Two-Plan Model) based on complex medical conditions shall not be approved for an eligible beneficiary who has:

1. Been a member of either plan on a combined basis for more than 90 calendar days.

2. A current Medi-Cal provider who is contracting with either plan.

3. Begun or was scheduled to begin treatment after the date of plan enrollment.

(§53887(a)(2)(B), effective December 19, 2000)

585-4C ADDED
1/16

Managed Care Plans are required to consider a request for exemption from Managed Care Plan enrollment that is denied as a request to complete a course of treatment with an existing fee for service or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the Managed Care Plan's contract with Department of Health Care Services and any other Department of Health Care Services continuity of care All Plan Letter. Managed Care Plans must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. The beneficiary's existing provider is identified by the National Provider Identifier on the Medical Exemption Request. Managed Care Plans must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under All Plan Letter 11-019, Duals Plan Letter (DPL) 14-004 on continuity of care, All Plan Letter 14-021 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care All Plan Letters and DPLs.
(All Plan Letter 15-001, January 14, 2015)

585-6

In the Two-Plan Model:

(a) The Health Care Options Program shall use a combined enrollment/disenrollment form in operating the Health Care Options Program. This form shall be made available at the health care options presentation and at designated sites. The form shall be mailed to a beneficiary within three working days of receiving a telephone or written request for a form.

(b) Plans shall make the form available at the member services departments and shall mail the forms to the beneficiary within three working days of receiving a telephone or written request for a form.

(§53888 as modified effective December 19, 2000)

585-7

In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider, among a number of criteria, that there is a preference for placing family members in the same plan. (§53884(b)(4))

585-8

State regulations provide that:

(a) Each plan (in a Two Plan model) shall ensure that primary health care services provided through the plan are no more than 30 minutes travel time or ten (10) miles travel distance from each member's place of residence, unless the department has approved an alternative time and distance standard.

(b) An eligible beneficiary may voluntarily choose to receive services from a plan service site with a travel time or distance that exceeds the requirements in subsection (a).

(§53885)

585-9 REVISED
4/12

Except for pregnancy, any eligible beneficiary in a Two-Plan Model granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by the beneficiary's treating physician up to 12 months from the date the medical exemption is first approved by the Health Care Options Program. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service Medi-Cal provider through delivery and the end of the month in which 90 days post-partum occurs.

Any extension to the 12-month medical exemption time limit shall be requested through the Health Care Options Program no earlier than 11 months after the starting date of the exemption currently in effect. The Health Care Options Program shall notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary

continues to meet the requirements of subsection (a)(2).

(§53887(a)(3) and (4), effective December 19, 2000)

585-10

Exemption from plan enrollment or extension (in the Two-Plan Model) of an approved exemption due to a complex medical condition shall be requested on the "Request for Medical Exemption from Plan Enrollment" form (HCO Form 7101, June 2000). Exemption from plan enrollment or extension of an approved exemption due to a beneficiary's enrollment in a Medi-Cal waiver program, as specified, or a beneficiary's acceptance for care at an Indian Health Service facility, shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO Form 7102, October 2000). The completed request for exemption shall be submitted by mail or fax to the Health Care Options Program by the Medi-Cal fee-for-service provider or the Indian Health Service facility treating the beneficiary. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(§53887(b), effective December 19, 2000)

585-11

In the Two-Plan Model, the Health Care Options Program shall accept and process all completed enrollment and disenrollment requests, including expedited disenrollment requests, from eligible beneficiaries within two working days of receipt if such requests meet the conditions for plan disenrollment specified in §53891.

Approval of enrollment and disenrollment requests is conditioned upon receipt of a fully completed enrollment/disenrollment form and all required supporting documentation.

The Health Care Options Program shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment, as specified in subsection (h) below.

(§53889(e), (f) and (g), effective December 19, 2000)

585-12

Nothwithstanding this article or section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994 except for contracts in county organized health systems.

Nothwithstanding any other provisions of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but not enrolled in a pilot project shall continue to submit billing for CCS services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts.

For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code.

(Welfare and Institutions Code (W&IC) §§14094.3(a), (b) and (e))

585-13

Services (in the California Children's Services Act) mean any or all of the following:

- Expert diagnosis
- Medical treatment
- Surgical treatment
- Hospital care
- Physical therapy
- Occupational therapy
- Special treatment
- Materials
- Appliances and their upkeep, maintenance, care and transportation
- Maintenance, transportation or care incidental to any other services

(Health and Safety Code §123840)

586-1

Each plan shall provide or arrange to provide for all Medi-Cal covered services, unless excluded under the contract, in accordance with the terms and provisions of the contract between the plan and the Department. The scope of services shall include preventive services, case management and emergency care. Each plan shall refer and coordinate for those services that are excluded under the contract, whether or not covered under Medi-Cal, pursuant to the requirements of the contract between the plan and the DHS. (§53851)

586-2 ADDED
8/14

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.

(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are

defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.

(c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(d) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography.

(e) Home health services, which shall include, where medically appropriate, health services provided at the home of an enrollee as prescribed or directed by a physician or osteopath licensed to practice in California. Such home health services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.

(1) Home health services may also include such rehabilitation, physical, occupational or other therapy, as the physician shall determine to be medically appropriate.

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,

(1) reasonable health appraisal examinations on a periodic basis;

(2) a variety of voluntary family planning services;

(3) prenatal care;

(4) vision and hearing testing for persons through age 16;

(5) immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;

(6) venereal disease tests;

(7) cytology examinations on a reasonable periodic basis;

(8) effective health education services, including information regarding personal health behavior and health care, and recommendations re- garding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(g) (1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. “Urgently needed services” are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. “Urgently needed services” includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(h) Hospice services as set forth in Section 1300.68.2.

Title 28 California Administrative Code (CAC) 1300.67

586-3 ADDED
8/14

Pursuant to W&I Code §14185(b), MCPs must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the

contracting physician. (All Plan Letter 13-023, December 24, 2013)

586-4 ADDED
8/14

When there is more than one drug that is appropriate for the treatment of a medical condition, a plan may require step therapy. A plan that requires step therapy shall have an expeditious process in place to authorize exceptions to step therapy when medically necessary and to conform effectively and efficiently with continuity of care requirements of the Act and regulations. In circumstances where an enrollee is changing plans, the new plan may not require the enrollee to repeat step therapy when that enrollee is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective for the enrollee's condition. Nothing in this section shall preclude the new plan from imposing a prior authorization requirement pursuant to Section 1367.24 for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former plan, or preclude the prescribing provider from prescribing another drug covered by the new plan that is medically appropriate for the enrollee. For purposes of this section, “step therapy” means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are to be prescribed. (28 CCR §1300.67.24(d)(2))

586-5 ADDED
1/15

Managed care services must be provided when medically necessary to “prevent disease, disability, and other health conditions or their progression,” “[p]rolong life,” and “[p]romote physical and mental health and efficiency” (Title 42, Code of Federal Regulations, Section 440.130(c)). The EPSDT benefit is more robust than the Medi-Cal benefit package provided to adults and is designed to ensure that eligible children receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. (DHCS All-Plan Letter (APL) No. 14-017, December 12, 2014)

586-6 ADDED
1/15

For managed care plan-covered services, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

Diagnose a mental health condition and determine a treatment plan;

Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and

Refer adults to the county mental health plan for specialty mental health services when a mental health diagnosis covered by the mental health plan results in significant impairment; or refer children under age 21 to the mental health plan for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the managed care plan beneficiary meets medical necessity criteria. (DHCS All Plan Letter (APL) No. 13-021,

December 13, 2013)

586-7 ADDED
1/15

Managed care plans (MCPs) must provide the services listed below, when medically necessary and provided by primary care providers or licensed mental health professionals in the MCP provider network within the scope of their practice:

Individual and group mental health evaluation and treatment (psychotherapy);

Psychological testing, when clinically indicated to evaluate a mental health condition;

Outpatient services for the purposes of monitoring drug therapy;

Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,

Psychiatric consultation.

Current Procedural Terminology codes that are covered can be found in the Medi-Cal Provider Manual. (DHCS All Plan Letter (APL) No. 13-021, December 13, 2013)

586-8 ADDED
1/15

Effective January 1, 2014, each MCP is obligated to cover and pay for mental health assessments of MCP beneficiaries with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual. This new requirement is in addition to the existing requirement that primary care providers offer mental health services within their scope of practice. MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools agreed upon by both the MCP and MHP), resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual (DSM). Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by an MCP nor by a mental health plan (MHP). All services must be provided in a culturally and linguistically appropriate manner. (All Plan Letter (APL) No. 13-021, December 13, 2013)

586-9 ADDED
1/15

Under a Medi-Cal managed care contract, the managed care plan: (i) must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished; (ii) may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary; and (iii) may place appropriate limits on a service: (A) on the basis of criteria applied under the State plan, such as medical necessity; or (B) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section. (42 Code of Federal Regulations §438.210(a)(3))

586-10 ADDED
10/15

In accordance with Welfare and Institutions Code § 14185(b), Managed Care Plans must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the Managed Care Plan, until the prescribed therapy is no longer prescribed by the contracting physician. (All Plan Letter 15-001, January 14, 2015)

586-11 ADDED
10/15

All-Plan Letter (APL) 15-012, August 21, 2015, identifies information that Managed Care Plans must review and consider during the prior authorization process as described and detailed in the attached guidelines for intravenous (IV) sedation and general anesthesia for dental procedures.

Criteria Indications for Intravenous Sedation or General Anesthesia

Behavior modification and local anesthesia shall be attempted first, conscious sedation shall then be considered if this fails or is not feasible based on the medical needs of the patient.

If the provider provides clear medical record documentation of both number 1 and number 2 below, then the patient shall be considered for intravenous sedation or general anesthetic.

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.

2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for intravenous sedation or general anesthetic.

3. Use of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient .

4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.

5. Patient has acute situational anxiety due to immature cognitive functioning.

6. Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order: conscious sedation via inhalation or oral anesthetics, intravenous sedation, then general anesthesia.

Patients with certain medical conditions such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders (i.e. continuous anticoagulant therapy such as Coumadin therapy) should be treated

in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

586-12 ADDED
10/15

A wheelchair is medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker. [emphasis added]

In the past, wheelchairs have been denied based on Medicare regulations, which limit wheelchair coverage to that necessary in the beneficiary's home. In contrast, Medi-Cal covers medically necessary equipment when it "is appropriate for use in or out of the patient's home" (Title 22, CCR, Section 51160). MCPs have an obligation to cover medically necessary DME, regardless of whether the needed equipment will be used inside or outside of the beneficiary's home. A prescription for a wheelchair or SPC may not be denied solely on the grounds that it is for use outside of the home when determined to be medically necessary for the beneficiary's medical condition.

Wheelchairs are still subject to prior authorization by the managed care plan under Title 22, CCR section 51321. They may be prescribed only after "a face-to-face examination by a licensed clinician and an evaluation performed by a qualified provider who has specific training and/or experience in wheelchair evaluation and ordering, as applicable, and as defined in Welfare and Institutions Code Section 14105.485." [emphasis added]

(All Plan Letter 15-018, July 9, 2015)