532-1
Durable medical equipment is equipment that must be able to withstand repeated use, must be used to serve a medical purpose, must be appropriate for use in or out of the patient's home, and must not be useful to an individual in the absence of an illness, injury or congenital anomaly. (§51160, as revised effective June 5, 2000)

532-2
Durable medical equipment is a covered Medi-Cal benefit when provided on the written prescription of a licensed practitioner within the scope of his/her practice. Prior authorization is required for the purchase of durable medical equipment when the cost exceeds $100, for the repair or maintenance of such equipment when the program cost exceeds $250, or for the cumulative rental of such equipment when the program cost exceeds $50. Authorization shall be limited to the lowest cost item that meets the patient's medical needs. Authorization shall not be granted for medical equipment when a household or furniture item will adequately serve the patient's medical needs.
(§51321)

532-2A ADDED
5/16 The repair or maintenance of durable medical equipment is a covered benefit. Prior authorization is required when the cumulative cost within the calendar month exceeds $250.00 for the repair and maintenance of items within a group, and when the cumulative cost of renting items within a group exceeds $50.00 within a fifteen month period. The cost of repairs shall not exceed the replacement value of the item being repaired.
(Cal. Code Regs, tit. 22, § 51321.)

532-2B ADDED
5/16 The following items are not covered by the Medi-Cal as durable equipment:

- Alterations or improvements of real property are not covered except to the extent authorized for the provision of home dialysis services.
- Modification of automobiles/or other highway motor vehicles;
- Books or other items of a primarily educational nature;
- Air conditioners, air filters, or heaters;
- Food blenders;
- Reading lamps, or other lighting devices;
- Bicycles, tricycles, or exercise equipment, except as otherwise specified in this Chapter;
- Television sets;
- Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items;
- Waterbeds;
- Household items; and
- Other items not generally used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them.

(Cal. Code Regs, tit. 22, § 51321.)

532-3
All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of his/her license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively. A written prescription and prior authorization are required for purchase, rental, or repair of such orthotic appliances when the program cost is more than $250. A written prescription and prior authorization are required for purchase, rental, or repair of such appliances when the program cost of such prosthetic services is more than $500. (§51315(a))

532-4
The CDHS issued emergency, and then permanent regulations, which excluded as "durable medical equipment" certain items, including stairway chairlifts. (See §51160(e)(11))

The California Court of Appeal, First Appellate District, held that CDHS stairway chairlifts could not be excluded by regulations when they were durable medical equipment and thus covered by statute, W&IC §14132(m). Thus, the regulation was invalid.

(Blue v. Bontá (2002) 99 Cal. App. 4th 980)

533-1
Medical transportation services are defined as 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, taxi cabs, or other forms of public or private conveyances. (§51151)

Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient. (§51323(b)(1)) Nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's, or a podiatrist's prescription and prior authorization. (§51323(b)(2))

533-2
State regulations at (§51323(a)) provide that:

(3) Wheelchair van services are covered when the patient's medical and physical condition:

(A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(B) Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation.

(C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(D) Does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation

(§51323(a)(3))

533-3
Nonemergency medical transportation is provided, subject to prior authorization, when necessary to obtain program covered medical services and when the beneficiary's medical and physical condition is such that transport by ordinary means of private or public conveyance is medically contraindicated. Each authorization request for such transportation must be accompanied by either a prescription or order signed by a physician, dentist, or podiatrist, which describes the medical reasons necessitating the use of nonemergency medical transportation.

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

(Manual of Criteria for Medi-Cal Authorization, §12.1.2, as renumbered effective June 5, 2000)

533-4
Examples of when a wheelchair van may be necessary include:

1. Beneficiary is wheelchair bound, and unable to self-transfer to a private or public conveyance, or cannot reasonably ambulate even with assistance or use of a walker or crutches so as to use a private or public conveyance, such as, but not limited to cases of:

    a. Bilateral amputee without prostheses.

    b. Severe paraplegic without bracing.

    c. General physical weakness and inability to ambulate without assistance due to old age.

2. Hemodialysis cases may be considered if there is sufficient documentation from the attending physician or by on-site visit that significant altered physical state pre- or post-treatment medically contraindicates the use of private or public transportation.

3. Cases with definite mental confusion where transport requires qualified attendant supervision.

4. Inpatient cases who are wheelchair bound and require transport to another facility for medically necessary tests such as CT scan, or radiation therapy.

(Manual of Criteria for Medi-Cal Authorization, §12.1.4., as renumbered effective June 5, 2000)

533-5
Contraindications to the use of private or public transportation (bicycle, car, taxi, bus) may involve, but are not necessarily limited to:

A. Acute, severe, emergent medical conditions such as respiratory distress.

B. Medical/physical conditions of the beneficiary where the beneficiary is:

1. Unable to ride upright in a private or public vehicle.

2. Unable to transfer into a private or public vehicle such as, but not limited to cases of:

a. Paraplegia.

b. Severe dysfunction of upper and lower extremities.

c. Severe deforming disease of back or lower extremities.

3. The medical condition precludes being able to reasonably ambulate to a vehicle or a bus stop or board a vehicle such as, but not limited to:

a. Lesions of the feet due to active disease.

b. Severe deforming disease of the back or lower extremities with definite limited range of motion.

c. Severe chronic asthenia due to disease, e.g., severe cachexia.

d. Wheelchair-bound cases due to chronic severe musculoskeletal and/or neurologic diseases; unable to stand or walk even with assistance.

e. Extreme weakness or history of recurring syncope.

4. The medical condition of the beneficiary, who has a special automobile, has progressed or changed so that the beneficiary cannot reasonably transfer into and/or drive the vehicle and/or use other private or public transport as in B.1., 2, or 3.

(Manual of Criteria for Medi-Cal Authorization, §§12.1.4 - 12.1.5, as renumbered effective June 5, 2000)

533-6
Federal regulations provide that a state Medicaid plan (Medi-Cal) must specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe the methods the agency will use to meet this requirement, (42 Code of Federal Regulations (CFR) §431.53)

534-1
Emergency services are 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.

For purposes of providing treatment of an "emergency medical condition" to otherwise eligible aliens pursuant to Welfare & Institutions Code §14007.5(d), this requires a medical condition (including emergency labor and delivery) with acute conditions of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency services are exempt from prior authorization. However, 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 treating or supervising physician's, podiatrist's, dentist's, or pharmacist's signed statement. This statement should describe the nature of the emergency, including relevant clinical information about the patient's condition, and state 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.

(§§51056(a)-(c))

534-2
Federal law governing medical assistance to aliens not lawfully admitted for permanent residence provides as follows:

(1) Except as provided in (2) below, no payment may be made to a state under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payments shall be made under this section for care and services that are furnished to an alien described in (1) above only if:

    (A) The care and services are necessary for the treatment of an emergency medical condition of the alien.

(B) The alien otherwise meets the eligibility requirements for medical assistance under the state plan approved under this subchapter (other than the requirement of the actual receipt of aid or assistance).

(C) The care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "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 either:

(A) Placing the patient's health in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(42 United States Code §1396b(v))

534-3
The position of the CDHS is that aliens who are not lawfully present in the United States are no longer eligible for state-funded nonemergency pregnancy-related services. This applies to all new applicants effective March 1, 1998, and to all current recipients of such services as of April 1, 1998.

If aliens are qualified (including aliens or their alien children who have been battered or subject to extreme cruelty in the United States, and for whom the U.S. Attorney general has determined eligibility), or "nonimmigrant aliens under the Immigration and Nationality Act (INA)", or aliens paroled into the U.S. for less than one calendar year under §212(d)(5) of the INA: Then those aliens may receive nonemergency pregnancy-related services.

(All-County Welfare Directors Letter (ACWDL) No. 97-22, May 30, 1997, p. 2, as modified by ACWDL No., 98-12, March 3, 1998)

535-1
Prescribed drugs shall be limited to no more than six per month unless: Prior authorization is obtained; the beneficiary is receiving care in a nursing facility; or the drugs are prescribed for family planning. (Welfare and Institutions Code (W&IC) §14133.22)

535-2
A Medi-Cal beneficiary may request a fair hearing when the Director of the CDHS proposes to delete or suspend a drug from the list of contract drugs. The beneficiary who files timely (within 90 days) receives a Treatment Authorization Request (TAR) for the drug throughout the appeal process until the matter is resolved by "the court". (Welfare and Institutions Code (W&IC) §§14105.405(a) and (b))

535-3 ADDED 3/06
Drugs on the Medi-Cal List of Contract Drugs are covered, subject to limitations specified in §51313 and §51313.3 when prescribed by a licensed practitioner within the scope of the practitioner's practice as defined in California law. (§51313(a))

Drugs not on Medi-Cal List of Contract Drugs and not excluded in §51313.3 are covered subject to prior authorization in accordance with §51003.

Authorization may be granted when:

(A) The clinical condition of the patient requires the use of an unlisted drug and listed drugs have been adequately considered or tried and do not meet the medical needs of the patient.

(B) The use of an unlisted drug results in a less expensive treatment than would otherwise occur. (§51313(c)(1))

535-3A ADDED 3/06
Authorization for unlabeled use of drugs shall not be granted unless the requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on:

(A) Reference to current medical literature.

(B) Consultation with provider organizations, academic and professional specialists (§51313(c)(4))

535-3B ADDED
5/16 Prescribed drugs dispensed on an emergency basis are exempt from prior authorization. However, any such emergency service shall conform to the definition of emergency services in Section 51056.

(Cal. Code Regs, tit. 22, § 51313, subd. (c)(3).)

535-4 ADDED 8/14
Step Therapy is an enhanced utilization management process, or set of drug use protocols, intended to promote safe and cost-effective drug use based on nationally accepted standards of care or well-documented clinical drug studies. (Medi-Cal Provider Manual, Drugs: Medi-Cal Contract Drugs List Part 8 – Step Therapy, p. 1 September 2007))

535-5 ADDED 8/14
According to Medicaid's legislative history, state programs like Medi-Cal must strike a careful balance between the deference due a treating physician's decision to prescribe a particular drug and the implementation of utilization controls, including prior authorization criteria, which ensure

that prescriptions are appropriate and medically necessary. (*Paleski* v. *State Dept. of Health Services* (2006) 144 Cal.App.4th 713, 735)

535-6 ADDED
7/15In evaluating whether to add or delete drugs from the Medi-Cal list of contract drugs, the director is required to consider five separate criteria including cost, efficacy, essential need, misuse potential, and safety, without regard for the order in which the criteria are presented. (§ 51313.6(a))

536-1
The provision of physical therapy 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. (§51309(d)(2)(C))

536-2
Physical therapy services shall be limited to treatment immediately necessary to prevent or reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital. (§51309(b))

536-3
A maximum of eight psychiatry services may be provided in any 120-day period without prior authorization. Prior authorization shall be required when more than eight psychiatry services are provided, except those provided on an emergency basis. (§51305(d))

The treatment plan for psychiatric services shall include the principal diagnosis and significant associated diagnosis; clinical information adequate to describe the physiological and functional limitations; prognosis; specific services to be rendered; the therapeutic goals to be achieved and the anticipated time needed to obtain those goals; and the drug regimen. (§51305(d)(2))

536-3A
"Prior authorization," "reauthorization" or "approval" means authorization granted by a designated Medi-Cal Consultant or by a PCCM plan in advance of the rendering of a service after appropriate medical, dental or other review. (§51003(a)) In the Mental Health Programs, see 9 CCR §1810.234.

536-4
Health care, under state law, shall include the following mental health services:

(a) Mental health services provided by a city or county.

(b) Mental health services provided in a Short-Doyle community mental health service or in a community mental health center organized under the Federal Community Mental Health Centers Act of 1963.

(c) Certain outpatient drug abuse services under the jurisdiction of the State Department of Alcohol and Drug Programs, provided by certified private or county providers.

(d) Inpatient hospital services in an institution for mental disease to persons of all ages, provided that such institution is certified as a psychiatric hospital under Title XVIII of the Social Security Act.

(e) Other diagnostic, screening, preventive, or remedial rehabilitative services designed to restore the individual to the best possible functional level, recommended by a physician or licensed practitioner of the healing arts, and provided in a facility, home, or other setting.

(W&IC §14021)

536-4A
"Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. (9 CCR §1810.227)

536-4B
"Specialty Mental Health Services" means:

(a) Rehabilitative Services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.

(b) Psychiatric inpatient hospital services.

(c) Targeted case management.

(d) Psychiatrist services.

(e) Psychologist services.

(f) EPSDT supplemental specialty mental health services.

(g) Psychiatric nursing facility services.

(9 CCR §1810.247)

536-5
MHPs are not responsible for providing or arranging to pay for certain services. These excluded services include services which are not mental health services (as defined in 9 CCR

§1810.247); out of state mental health services, except when it is customary to receive such services from a border state; specialty mental health services provided by a hospital operated by the California Department of Developmental Services, or those provided to a Medicare beneficiary who has not exhausted those mental health benefits, or those covered by a Medi-Cal Managed Care Plan in which the person is enrolled; certain psychiatric inpatient hospital services; and certain Medi-Cal services that include specialty mental health services as a component of a larger service package. (9 CCR §1810.355(a))

Beneficiaries whose diagnoses are not included in the applicable list of diagnoses in 9 CCR §§1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Division 3, Subdivision 1. (9 CCR §1810.355(b))

536-6
The MHP of the beneficiary shall refer the beneficiary to a source of treatment or a source of referral for treatment outside the MHP when the MHP determines that the beneficiary's diagnosis is not included in 9 CCR §1830.205(b)(1) or is included but would be responsive to physical health care based treatment. Whenever possible, the MHP shall make the referral to a provider with whom the beneficiary already has a patient-provider relationship. Where appropriate, the MHP may make the referral to certain health care options programs. The MHP of the beneficiary shall not be required to ensure the beneficiary's access to physical health care based treatment or to treatment from licensed mental health professionals for diagnoses not covered in 9 CCR §1830.205(b)(1). (9 CCR §1810.415(d))

536-8
In an outpatient setting, there are medical necessity criteria which determine whether the beneficiary is entitled to services from the Mental Health Plan (MHP).

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual (DSM), Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in §1830.210, a probability a child (i.e., a person under 21 years of age) will not progress developmentally as individually appropriate.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in §1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

(9 CCR §1830.205, implementing W&IC §14680)

536-8A
Federal regulations provide, in pertinent part, that:

(b) A state plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility.

(1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines

eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

536-9
Title 9 of the California Code of Regulations (CCR) deals with provision of out-of-plan services.

(a) "Out-of-Plan Services" are specialty mental health services covered by this subchapter, other than psychiatric nursing facility services, which are not provided by the Mental Health Plan (MHP) or a provider contracting with the MHP.

(b) The MHP shall be required to provide out-of-plan services only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in §1820.225 to the extent provided in §1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in §1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on an evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of

providers in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program, the Adoption Assistance Program, or other foster care arrangement.

(B) A Lanterman-Petris-Short or Probate Conservator or other legal involuntary placement.

(9 CCR §1830.220)

536-10
Whenever feasible, the MHP, at the beneficiary's request, shall provide the beneficiary who meets the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary, and an opportunity to change that person at a later date. The MHP may limit the beneficiary's choice, at the election of the MHP, to a choice between two of the individual providers contracting with the MHP or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary. (9 CCR §1830.225)

536-11
Title 9 of the California Code of Regulations (CCR) deals with Notice of Action (NOA) requirements sent by the Mental Health Plan (MHP).

(a) The MHP shall provide a beneficiary with an NOA when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title 22, §51014.1. An NOA under this subsection shall not be required in the following situations:

(1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with an NOA when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The NOA shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary an NOA to deny the service pursuant to subdivision (a). If, within that 30-day period, the provider does comply, the MHP shall

take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing an NOA to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The NOA under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with an NOA when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, §51014.1. The NOA pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The NOA under this subsection shall not be required when the MHP modifies an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(9 CCR §1850.210)

536-11A
When a Notice of Action (NOA) would not be required under 9 CCR §1850.210 (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with an NOA when the MHP or its providers determine that the medical necessity criteria in §1830.205(b)(1), (b)(2), or (b)(3)(C) or §1830.210(a) have not been met and that the beneficiary is not entitled to any specialty mental health services from the MHP. This NOA shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with 9 CCR §1850.210(d) and shall specify:

(1) The reason the medical necessity criteria was not met.

(2) The beneficiary's options for obtaining care outside the MHP, if applicable.

(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file a complaint or grievance with the MHP.

(5) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limits for requesting a fair hearing.

(9 CCR §1850.210(i))

536-11B
The written NOA issued pursuant to 9 CCR §1850.210(a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting a fair hearing.

(9 CCR §1850.210(d))

536-11C
In addition to any notice mailed pursuant to §§50179, 53261, 53452, 56261, or 56452, each beneficiary shall be informed by notice, in writing, of the right to a fair hearing when there is:

(1) Any action, other than approval, including but not limited to deferral or denial, taken by the Department or a Medi-Cal managed care plan on a request by a provider for any medical service.

(2) Any intended action by the Department or a Medi-Cal managed care plan to terminate or reduce any medical service.

(§51014.1(a))

536-11D
Except as provided in §51014.1(d), notice of intended action to reduce or terminate authorization for a medical service (i.e., a service that is subject to prior authorization) prior to expiration of the period covered by the authorization shall be mailed by the Department or by

the Medi-Cal managed care plan to the beneficiary at least 10 days before the effective date of action. The notice shall include:

(1) A statement of the action the Department or Medi-Cal managed care plan intends to take.

(2) The reason for the intended action.

(3) A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action.

(4) An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the Department's or Medi-Cal managed care plan's decision.

(5) An explanation of the procedure to request a hearing.

(6) An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.

(§51014.1(c) and (i))

536-11E
Continued medical assistance as set forth in §51014.2(b), (c), and (d) pending a hearing decision shall be provided if the beneficiary appeals in writing to the Department for a hearing within 10 days of the mailing or personal delivery of the notice of action pursuant to §51014.1(c), (e) or (f), or before the effective date of the action. (§51014.2(a))

In the case of a termination or reduction pursuant to §51014.1(c), authorization shall be maintained until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest. (§51014.2(b))

536-11F ADDED 8/05
The current option for beneficiaries to file for a state hearing at any time before or after the Mental Health Plan (MHP) problem resolution process will cease. Beginning July 1, 2005, beneficiaries will be required to exhaust the MHP's problem resolution process prior to filing for a state hearing. (Department of Mental Health Letter 05-03, June 2, 2005)

536-11G ADDED 8/05
As of July 1, 2005, MHPs are required to provide aid paid pending to beneficiaries who continued services and have filed a timely request (10 days from the date the Notice of Action was mailed, or 10 days from the date the NOA was personally given to the beneficiary, or before the effective date of the change, whichever is later), for an appeal or state hearing. The beneficiary must either have an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied renewal by the MHP, or have been receiving

specialty mental health services under an “exempt pattern of care”. (Department of Mental Health Letter 05-03, June 2, 2005)

536-12
A beneficiary receiving specialty mental health services pursuant to 9 CCR, Chapter 11, shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to 22 CCR §51014.2. For the purpose of this section, each reference to Medi-Cal managed care plan in 22 CCR §51014.2, shall mean the MHP. The time limits for filing for a continuation of services pursuant to 22 CCR §51014.2 shall not be extended by a beneficiary’s decision to pursue an MHP’s beneficiary problem resolution process as described in 9 CCR §1850.205.

(9 CCR §1850.215)

536-15
The CDHS shall add case management services as a benefit under the Short-Doyle Medi-Cal program for persons served by the State Department of Mental Health and Short-Doyle mental health programs. (W&IC §14021.3)

536-16
Community mental health services, as defined in §51341(b), provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program. (§51341(a))

"Community mental health services" include acute inpatient hospital services, psychiatric health facility services, mental health services, medication support, day treatment intensive service, day rehabilitation service, adult and crisis residential treatment services, crisis intervention, and crisis stabilization-emergency room or urgent care. (§51341(b))

536-17
Short-Doyle drug Medi-Cal substance abuse services, as defined in §§51341.1(b)-(d), provided to Medi-Cal beneficiaries, are covered by the Medi-Cal program when determined medically necessary under §51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in §51159. (§51341.1(a))

537-1
A request for acute continuing care services means a request for extension of approval for acute care services in hospitals with on-site Medi-Cal reviewers when:

(A) The treating physician certifying the need for acute care has determined that the beneficiary cannot be safely discharged because acute care services continue to be medically necessary for one of the following reasons:

1. Further acute care is needed for the purpose of treating the condition(s) for which acute care was originally approved for an acute condition requiring prior authorization.

2. Complications directly related to the diagnosis for which acute care was originally approved have arisen and necessitate further care.

3. Further acute care is needed for an illness contracted during the course of an acute admission if the illness most likely occurred because the patient was hospitalized.

4. Further acute care is needed for the purpose of treating a diagnosed condition(s) for which a length of stay was previously approved after an emergency or urgent admission.

5. Further diagnostic procedures and/or treatments are needed after a previously approved emergency or urgent admission for which no length of stay was approved and the acute care stay has been at least five days in duration at the time of the request; and the medical record contains documentation consistent with subdivision (c)(2)(A).

(§51003(c)(2))

537-2
The CDHS has established a model format and general criteria for hospital services with specific psychiatric diagnoses:

I. Clinical Information are:

> Indications for Admission

> Usual indications for admission common to all disorders

A. Danger to self, others, or property as a result of a mental disorder and/or

B. Seriously disordered behavior accompanied by impaired reality testing and/or

C. Need for planned medical evaluation, special drug therapy, or special treatment requiring continued hospitalization or continuous skilled observation following failure of treatment modalities available in outpatient, community or extended care settings and accompanied by impaired social, familial and or occupational functioning and/or

D. Specific additional indications as listed under the particular diagnosis.

II. Documentation

A. Pertinent clinical findings

Documentation of clinical information and indications for admission listed in 1., above

B. Pertinent laboratory findings

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

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

E. Continuation of indications for admission without the presence of a discharge criterion.

F. Serious adverse reaction to drugs, procedures or therapies.

G.-H. Specific additional indications as listed under the particular diagnosis.

(Manual of Criteria for Medi-Cal Authorization, §5.2.1)

537-3
Psychiatric Hospitalization Guidelines are issued as an adjunct to the Manual of Criteria for Medi-Cal Authorization and represent a consensus reached by the CDHS, the Department of Mental Health, the statewide Peer Review Organization Council, the California Psychiatric Association, and representatives from community mental health programs.

The following criteria deal with the Physician's Documentation and are part of §1:

A. Essential elements to justify admission:

1. Specific description and examples of the patient's condition and behavior which justifies the medical necessity for acute psychiatric hospitalization.

2. Statement why the patient cannot be treated on an outpatient basis.

3. Brief summary of the patient's previous history and treatment.

4. Tentative diagnosis.

5. Treatment plan which should include problem formulation, treatment goals, and proposed therapeutic modalities.

6. Results of pertinent pre-admission tests and evaluations.

B. The admitting note should be charted within 12 hours of admission.

C. History and physical and mental status evaluation should be charted within 24 hours of admission.

D. For Extensions of Stay:

1. Daily psychiatrist's progress notes indicating patient's current mental status and clinical progress, including reasons that acute inpatient care is still required.

2. Description of any changes to the original treatment plan.

3. Statement of results of overall treatment since admission.

4. Statement with sufficient clinical detail to permit an independent evaluation of the level of care and estimated length of stay.

E. Some examples of clinical findings supporting admission are:

1. Suicide attempt or suicidal ideation with defined plan.

2. Uncontrolled assaultive or self-mutilative behavior.

3. Acute delirium and/or mania.

4. Acute bizarre or delusional behavior.

5. Impaired judgment, memory, intellect or orientation accompanied by difficulty in controlling patient.

(Psychiatric Hospitalization Guidelines, §1)

537-4
A "Medi-Cal day of acute inpatient hospital service" means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California State Plan, including any day of service that is reimbursed on a basis other than per-diem payments. (Welfare and Institutions Code (W&IC) §14105.98(a)(17))

538-1
Criteria for authorizing hearing aids include:

(a) Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or a licensed audiologist.

(b) Prior to prescribing a hearing aid, the otolaryngologist or attending physician shall perform a complete ear, nose and throat examination.

(f) Authorization for hearing aids may be granted only when:

(1) Tests of the better ear, after treatment of any condition contributing to the hearing loss, reveal an average hearing loss level of 35 dB or greater, ANSI, 1969, for 500, 1,000 and 2,000 Hertz (Hz) by pure tone air conduction, or:

(2) The difference between the level of 1,000 Hz and 2,000 Hz is 20 dB or more, the average of the air conduction threshold at 500, 1000 and 2,000 Hz need only be 30 dB hearing level, (ANSI, 1969), and

(3) Speech communication is effectively improved or auditory contact is necessary for sound awareness (personal safety) in the environment in which the beneficiary exists.

(§51319)

538-2
Replacement of a hearing aid may be authorized only if:

(1) The prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control.

(2) The hearing impairment of the beneficiary requires amplification or correction not within the capabilities of the beneficiary's present hearing aid.

(§51319(g))

538-3
Podiatry services are covered by the Medi-Cal Program. 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. 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 disorders of the feet which significantly impair the ability to walk. (§51310)

538-3A ADDED 4/11
Podiatry services are no longer a benefit of the Medi-Cal program effective July 1, 2009. Welfare and Institutions Code (W&IC) 14131.10(F).

538-4 REVISED 12/08
"Adult day health care" means an organized day program of therapeutic, social, and health activities and services provided pursuant to this chapter to elderly persons with functional

impairments, either physical or mental, for the purposes of restoring or maintaining optimal capacity for self-care. (§54103)

538-9 ADDED 12/08
The following definitions shall apply for the purposes of this chapter:

(a) "Activities of daily living" (ADL) means activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation, and transferring.

(b) "Instrumental activities of daily living (IADL) means functions or tasks of independent living, including hygiene, medication management, transportation, money management, shopping, meal preparation, laundry, accessing resources, and housework.

(c) "Personal health care provider" means the participant's personal physician, physician's assistant, or nurse practitioner, operating within his or her scope of practice.

(d) "Care coordination" means the process of obtaining information from, or providing information to, the participant, the participant's family, the participant's primary health care provider, or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as indentified by one or more members of the multidisciplinary team.

(e) "Facilitated participation" means an interaction to support a participant's involvement in a group or individual activity, whether or not the participant takes active part in the activity itself.

(f) "Group work" means a social work service in which a variety of therapeutic methods are applied within a small group setting to promote participants' self-expression and positive adaptation to their environment.

(g) "Professional nursing" means services provided by a registered nurse or licensed vocational nurse functioning within his or her scope of practice.

(h) "Psychosocial" means a participant's psychological status in relation to the participant's social and physical environment.

(W&IC§14522.3)

538-9A ADDED 12/08
Any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

(a) the person is 18 years of age or older and has one or more chronic or post acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.

(b) The person has functional impairments in two or more activities of daily living, instrumental activities of daily living, or one or more of each, and requires assistance or supervision in performing these activities.

(c) The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.

(d) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
(e) Notwithstanding the criteria established in subdivisions (a) to (d), inclusive, of this section, any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(W&IC§14525)

538-9B ADDED 12/08
Participation in an adult day health care program shall require prior authorization by the department. The authorization request shall be initiated by the provider and shall include the results of the assessment screening conducted by the provider's multidisciplinary team and the resulting individualized plan of care.

Participation shall begin upon application by the prospective participant or upon referral from community or health agencies, or the physician, hospital, family, or friends of a potential participant.

(W&IC §14526

538-9C ADDED 12/08
Initial and subsequent treatment authorization requests may be granted for up to six calendar months. (W&IC §14526.1(a))

538 -9D ADDED 12/08

Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) The signature page of the history and physical form that shall serve to document the request for adult day health care services. A complete history and physical form, including a request for adult day health care services signed by the participant's personal health care provider, shall be maintained in the participant's health records. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(W&IC §14526.1(b))

538-9E ADDED 12/08
Authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:
(A) Monitoring
(B) Treatment
(C) Intervention

(2) The participant has a condition or conditions resulting in both of the following;
(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.

(B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). that assistance or supervision shall be in addition to any other non-adult day health care support the participant is currently receiving in his or her place of residence.

(3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5 on each day of attendance that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(W&IC §14526.1(d)

538-9F ADDED 12/08
Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(W&IC §14526.1(e)

538-10
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.

(§51184(a))

538-11
EPSDT diagnosis and treatment services means only those services provided to persons under 21 years of age that:

(1) Are identified in §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 §1396d(a)(4)(B) and §1396a(a)(43) of Title 42 of the United States Code; and

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

(§51184(b))

538-12
EPSDT supplemental services means health care, diagnostic services, treatment, and other measures, that:

(1) Are identified in §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 §51340(e), and

(4) Are not EPSDT diagnosis and treatment services.

(§51184(c))

EPSDT supplemental services include EPSDT case management services when provided by EPSDT case managers described in paragraph (h)(4). (§51184(d))

EPSDT case management services means services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services. (§51184(g))

EPSDT supplemental services include pediatric day health care EPSDT services when provided by a pediatric day health care facility. (§51184(j))

538-13
Requests for prior authorization for EPSDT supplemental services shall include the following information:

(1) The principal diagnosis and significant associated diagnoses.

(2) Prognosis.

(3) Date of onset of the illness or condition, and etiology, if known.

(4) Clinical significance or functional impairment caused by the illness or condition.

(5) Specific types of services to be rendered by each discipline associated with the total treatment plan.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.

(7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.

(8) Any other documentation available which may assist in making the required determinations.

(§51340(d))

538-14
"Pediatric day health care EPSDT services" are defined in §51184(l).

These services are designed to provide medically necessary skilled nursing care (see §51340.1(2)(A)) and therapeutic intervention (see §51340.1(2)(C)). These services may include occupational, speech, physical and medical nutrition therapy, if properly requested by the attending physician and provided by appropriately licensed or registered persons.

These services do not include respite care, per W&IC §14132.10(a).

(§51184(l)(1)(B))

538-15 REVISED 8/14
PACE is a federal program authorized by Section 902 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. It is a model of managed care service delivery for the frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid benefits, and all of whom are assessed as being eligible for nursing home placement according to the standards established in their respective States. See, generally, 42 Code of Federal Regulations (CFR) Part 460. PACE is authorized in California under Welfare and Institutions Code (W&IC) §14132.94(a))

538-16 ADDED 9/13
A PACE program must have an agreement with the Centers for Medicare and Medicare Services of the U.S. Department of Health and Human Services and that State administering agency for the operation of a PACE program by the PACE organization under Medicare and Medicaid.

The PACE benefit package for all participants must include all Medicare-covered items and services, all Medicaid-covered items and services and other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status. (42 C.F.R. §§460.30, 460.90)

538-17 ADDED 9/13
The PACE organization must have a formal written appeals process, with specified timeframes for response, to address noncoverage or nonpayment of a service.

Upon enrollment, and at least annually thereafter, and whenever the interdisciplinary team denies a request for services or payment, the PACE organization must give a participant written information on the appeals process. A PACE organization must give all parties involved in the appeal appropriate written notification and a reasonable opportunity to present evidence realted to the dispute, in person, as well as in writing.

During the appeals process, the PACE organization must meet the following requirements:

1) For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met:
    a) The PACE organization is proposing to terminate or reduce services current being furnished to the participant
    b) The participant requests continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.
2) Continue to furnish to the participant all other required services.

A PACE organization must inform a participant in writing of his or her appeal rights under Medicare or Medicaid managed care, or both, assist the participant in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity. (42 C.F.R. §460.124)

538-18 ADDED 9/13
To be eligible to enroll in PACE, an individual must meet the following requirements:

(1) Be 55 years of age or older.
(2) Be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services.
(3) Reside in the service area of the PACE organization.
(4) Meet any additional program specific eligibility conditions imposed under the PACE program agreement.

(42 CFR §460.150)

538-19 ADDED 9/13

Enrollment continues until the participant's death, regardless of changes in health status, unless either the participant voluntarily disenrolls, or the participant is involuntarily disenrolled, as described in §460.164. (42 C.F.R. §160(a))

538-20 ADDED 9/13
At least annually, the State administering agency must reevaluate whether a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services. The state administering agency may permanently waive the annual recertification requirement for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity. (42 C.F.R. §460.160(b))

538-21 ADDED 9/13
A participant may be involuntarily disenrolled if he or she is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.

Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

(42 C.F.R. §460.164(a))

In disenrolling a participant, a PACE organization must take the following actions:

1) Use the most expedient process allowed under Medicare and Medicaid, as set forth in the PACE program agreement.
2) Coordinate the disenrollment between Medicare and Medicaid for a participant who is eligible for both Medicare and Medicaid.
3) Give reasonable advance notice to the participant.

Until the date enrollment is terminated, the following requirements must be met:

1) PACE participants must continue to use PACE organization services and remain liable for any premiums.
2) The PACE organization must continue to furnish all needed services.

(42 C.F.R. §460.166)

To facilitate a participant's reinstatement in other Medicare and Medicaid programs after disenrollment, the PACE organization must do the following:

a) Make appropriate referrals and ensure medical records are made available to new providers in a timely manner.
b) Work with CMS and the State administering agency to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

(42 C.F.R. §460.168)

A PACE organization must:

a) Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.
b) Make documentation available for review by CMS and the State administering agency.
c) Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

(42 C.F.R. §460.172)

538-22 ADDED 9/13
If the State administering agency determines that a PACE participant no longer meets the State Medicaid nursing facility level of care requirements, the participant may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under the program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

1) The State administering agency must establish criteria to use in making the determination of "deemed continuing eligibility." It shall make a determination of deemed continued eligibility based on a review of the participant's medical record and plan of care in consultation with the PACE organization. These criteria must be applied in reviewing the participant's medical record and plan of care.
2) The criteria used to make the determination of continued eligibility must be specified in the program agreement.

42 CFR §460.160(b)(2) and (3)

539-1
A writ of mandate was issued by the Alameda County Superior Court on March 21, 1989. Pursuant to that writ, a Memorandum of Understanding (MOU) was entered into by plaintiffs and DHS in March 1990. This MOU required that aid paid pending be issued for reauthorized Treatment Authorization Requests (TARs) involving: Long-Term Care (LTC); chronic hemodialysis; hospice care; in-home medical care services; Skilled Nursing Facility (SNF) waiver services, model community-based waiver services; and all other non-acute care services covered under the Medi-Cal Program when the treating physician substantiates that services should be continued because the treatment goal on the original TARs has not been achieved. In order to receive aid pending, the claimant must file a hearing request within ten days of the mailing of an adequate notice reducing or terminating services, or at any time up to and including the last date on which services were authorized under the prior TAR, whichever is later. (*Frank* v. *Kizer*, Alameda County Superior Court, No. 646142-9)

539-2
The Department of Health Services (CHS) agreed to a final settlement in Federal District Court in the case of *Jackson* v. *Rank*. The settlement requires that DHS send a Notice of Action (NOA) to Medi-Cal recipients in almost all cases when a Treatment Authorization Request (TAR) has been submitted by the recipient's physician, and that TAR is denied in whole or in part. (The main exception to this general rule involves denial of a TAR for a specific drug, and an identical drug is available which does not require prior authorization.) (All-County Welfare Directors Letter No. 86-8, March 6, 1986, implementing *Jackson* v. *Rank*, Federal District Court, E.D. Cal., Case No. CIV 83-1451 LKK)