Revised: January 2010
Approval: [signature]

Health Education

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, §§ 51179, 51348, 51303)
(DHCS Contract 04-35765, Amend. 10, Exhibit A, Attach. 10, § 8)

Health education services, clinical preventive services, health education and promotion and patient education and counseling are covered services using one-to-one and group interventions, written and audiovisual materials.

Benefit Exclusion

Exercise classes (fitness centers) and diet counseling (weight control programs) done outside the participating physician's office or not offered as a part of the health plan's wellness programs are not covered.

Examples of Covered Benefits

1. Member Education:
   a. Use of clinical preventive services
   b. Available local Social and Health Care programs
2. Clinical Preventive Services; Education and Counseling:
   a. Nutrition
   b. Tobacco prevention and cessation
   c. Human Immunodeficiency Virus (HIV)/Sexually Transmitted Disease (STD) prevention
   d. Family planning
   e. Exercise (e.g., cardiac rehab)
   f. Perinatal
   g. Immunizations
   h. Injury prevention
   i. Age specific anticipatory guidance – EPSDT
3. Patient Education and Clinical Counseling:
   a. Diabetes
   b. Asthma
   c. Hypertension
   d. Substance abuse
   e. Tuberculosis
   f. Inpatient-Condition specific
   g. Other outpatient-condition specific

Health Education (continued)

Examples of Non-Covered Benefits

1. Exercise classes outside the participating physician's office that are not a part of one of the health plan's wellness programs.
2. Diet counseling outside the participating physician's office that are not a part of one of the health plan's wellness programs.

Hearing Aids

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51319)

NOTE: Children less than 21 years of age receiving hearing aids must be referred to California Children's Services (CCS). Benefit coverage is limited to one hearing aid assessment in any 12 month period.

Hearing aids are covered only when supplied by a licensed, approved hearing aid supplier and when prior authorization from the contracted IPA has been obtained. Requests for authorization must include the prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, and an audiological evaluation including a hearing aid assessment performed by the dispensing practitioner, either a physician, a licensed audiologist or a licensed hearing aid dispenser acting within their scope of practice. Prior to prescribing a hearing aid, the otolaryngologist or attending physician shall perform a complete ear, nose and throat examination. Authorization requests should include the results of the following tests:

1. Pure tone air conduction threshold and bone conduction tests of each ear at 500, 1,000, 2,000, 3,000 and 4,000 Hz with effective masking, as indicated.

2. Speech tests, aided and unaided to include:
   a. Speech Reception Threshold (SRT) using Spondee words.
   b. A Word Discriminating Score (WDS) derived from testing at 40 decibels (dB) above the SRT or at the Most Comfortable Loudness (MCL) using standard discrimination word lists, using either recorded or live voice.
   c. Sound Field Aided and Unaided, Speech Scores (SRT and WDS) shall be established.

3. Test results should include proposed hearing aid specifications.

4. Authorizations for hearing aids should be granted only when:
   a. 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, (American National Standards Institute (ANSI), 1969), for 500, 1,000, and 2,000 Hz by pure tone air conduction; or
   b. 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, 1,000 and 2,000 Hz need only be 30 dB hearing level (ANSI, 1969); and

Hearing Aids (continued)

Benefit Coverage (continued)

c. Speech communication is effectively improved and auditory contact is necessary for sound awareness (personal safety) in the environment in which the patient exists.

5. Replacement of hearing aid may be authorized only if:
   a. The prior hearing aid has not been lost, stolen or irreparably damaged due to circumstances beyond the beneficiary's control. The request shall include each of the following:
      1) A statement describing the circumstances of the loss, theft or destruction of the hearing aid, signed by the beneficiary and the otolaryngologist or the attending physician if there is no otolaryngologist available in the community; and
      2) An audiological evaluation, if other than a duplicate of the prior hearing aid is required.
   b. The hearing impairment of the patient required amplification or correction not within the capabilities of the patient's present hearing aid.

6. Programmable or Digital Hearing Aids
   a. Programmable or digital hearing aid systems require prior authorization that includes:
      1) Manufacturer name and model or serial number; and
      2) Copy of the manufacturer's wholesale catalog page with the hearing aid description and price.
   b. To qualify for a digital hearing aid (V5298 – hearing aid, not otherwise classified) the patient must have an average hearing loss of 50 dB or greater.
   c. To qualify for a more powerful hearing aid (V5050, V5060, V5130, V5140) the patient must meet both the following for progressive hearing loss:
      1) An average of 50 dB or greater hearing loss, with progressive hearing loss; and
      2) Must show a decrease of more than 20 dB average pure tone frequency and subsequent audiograms.

Benefit Exclusion

Replacement hearing aid batteries are not covered.

Hearing Aids (continued)

Examples of Covered Benefits

1. Limited to one hearing aid assessment in any twelve (12) month period.

2. Hearing aid, hearing aid cords, receivers, and ear molds.

3. Binaural hearing aids, with any of the following conditions:
   a. The hearing loss is associated with legal blindness.
   b. For patients 20 years of age or under, tests of each ear reveal a hearing loss level of 30 dB or greater (ANSI, 1969) for 500, 1,000 and 2,000 Hz by pure tone air conduction. Cases shall be referred to CCS for evaluation, consultation or case management for CCS eligible patients.
   c. For patients over 18 years of age, tests of each ear reveal a hearing loss level of 35 dB or greater (ANSI, 1969) for 500, 1,000 and 2,000 Hz by pure tone air conduction. Where provision of a binaural hearing aid is the basis for employment, patients with the above hearing loss shall be referred to the Department of Rehabilitation for evaluation, consultation and case management.

4. Initial hearing aid batteries supplied with the hearing aid are covered when supplied with a prior authorized hearing aid. Subsequent hearing aid batteries are the patient's responsibility.

5. Eyeglass hearing aids are covered when the requirements of the California Code of Regulations, Title 22, Sections 51319 and 51317 are met simultaneously.

Examples of Non-Covered Benefits

1. Replacement hearing aid batteries are not covered.

Hearing Screening

NOTE: The State of California eliminated the audiology benefit for adults age 21 and over effective July 1, 2009. Medically necessary adult audiology services may be covered on a case by case basis. Hearing aids are still a benefit and an audiogram is required to verify that the hearing loss is significant enough to justify the device.

Benefit Coverage (Members up to age 21)

Routine hearing screening by a licensed health professional to determine the need, if any, for hearing correction is covered.

Children less than 21 years of age receiving hearing screening must be referred to California Children's Services (CCS).

Benefit Exclusion

Audiometric testing, once determination has been made that the condition is likely to be uncorrectable is not a covered benefit.

Examples of Covered Benefits (Members up to age 21)

1. Hearing screening services to determine the need for hearing correction. These services may include the use of an office screening audiometer, tuning fork or whispered number recognition.
2. Full audiometric testing for hearing loss.
3. Audiometric testing to determine the appropriate type of hearing aid.

Examples of Non-Covered Benefits

1. Continued audiometric testing for conditions considered unlikely to be correctable (e.g., drug-induced hearing loss, eighth nerve damage, congenital rubella).
2. Routine Audiometric exams are not a Medi-Cal benefit for persons 21 years of age and older.

Hemodialysis

Definition (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51157)

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

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51330)

Hemodialysis for a chronic condition is covered only as an outpatient service. Prior authorization from the contracted IPA must be obtained for dialysis, physician services, medical supplies, equipment and drugs required for dialysis services, when provided by renal dialysis centers or community hemodialysis units. Inpatient hemodialysis is covered for temporary kidney failure due to an acute illness or injury.

Examples of Covered Benefits

Hemodialysis or peritoneal dialysis is a benefit for patients with kidney failure secondary to an acute injury, illness or drug overdose. The following services are considered to be a part of hemodialysis:

1. Services in an outpatient dialysis center.
2. Dialysis services while confined as an inpatient.
3. Ultrafiltration in cases where excess fluid cannot be removed easily during the regular course of hemodialysis.
4. Hemoperfusion when used in the treatment of an acute drug overdose.
5. Hemofiltration (diafiltration) is an alternative to hemodialysis and peritoneal dialysis in high risk, unstable patients with cardiovascular diseases or diabetes.

Examples of Non-Covered Benefits

1. Home water purification systems.
2. Adjustable chairs.
3. Hemodialysis for the treatment of schizophrenia.

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Home Health Care

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51337)

Home health agency services are covered for Members only as specified below when prior authorization is obtained from the contracted IPA. Authorized services are arranged through a provider contracted with the IPA and are provided at the home of the Member in accordance with a written treatment plan which the physician reviews every 60 days. The plan shall indicate the need for one or more of the following:

1. Part-time or intermittent skilled nursing services by licensed nursing personnel.
2. In-home medical care services as provided in the California Welfare and Institutions Code section 14132(t).
3. Physical, occupational, or speech therapy.
4. Medical social services.
5. The services of a home health aide.
6. Provision of medical supplies, other than drugs and biologicals.
7. The use of medical appliances, provided for under an approved treatment plan.
8. The Member must be confined to home secondary to physical limitation (homebound).

All home health services, including evaluations, generally require prior authorization by the contracted IPA.

In-home medical care services (Cal. Code Regs., tit. 22, § 51344) are covered when authorized by a physician and provided at the patient's place of residence in accordance with a written treatment plan indicating the need for in-home medical services. All in-home medical care services are subject to prior authorization, which will be granted only:

1. If the patient would otherwise require care in an inpatient acute care hospital for an extended period of time; and
2. If the cost of providing in-home medical care services is less than the cost of providing care to the patient in an inpatient acute care hospital.

Home Health Care (continued)

Benefit Exclusion

Non-homebound patients (patients are capable of getting to an outpatient setting).

Examples of Covered Benefits

1. Services of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
2. Home Health Aide.
3. Instructions to the patient and/or household members on use of equipment, or training for giving of injections.
4. Short-term physical therapy if patient is unable to travel.
5. Sterile dressing changes to open wound.
6. Intravenous infusions.
7. Medical supplies including diapers, rubber sheets, bandages.

Examples of Non-Covered Benefits

1. Custodial care (routine) or convalescent care not requiring skilled nursing.
2. Maintenance care of colostomy, ileostomy, percutaneous tubing, gastrostomy and tracheostomy wounds, unless medically necessary.
3. Routine home health care when the medical condition is stable and the services could be provided by a non-licensed individual and when professional monitoring of the patient on a daily basis is no longer medically necessary.

Home Use of Oxygen

Benefit Coverage

Home oxygen use is considered reasonable and necessary only for patients with significant hypoxemia and requires prior authorization by the contracted IPA. Significant hypoxemia is evidenced by the following:

1. PO_2 - At or below 55mm Hg or arterial O_2 saturation (ABO_2) at or below 88 percent at rest with room air.
2. For PO_2 at or above 60mm Hg, or on ABO_2 saturation at or above 90 percent, **coverage will not be routinely approved**. Attending physician must certify medical necessity.

The authorization request must include the following:

1. Medical documentation, including a diagnosis of the disease requiring home use of oxygen (COPD, Cystic Fibrosis, pulmonary neoplasm, diffuse interstitial lung disease or hypoxia related symptoms), as well as an estimate of frequency and duration of need.
2. Medical documentation must include flow rate and oxygen concentration. Arterial blood gas (ABG) must have inspired O_2 concentration documented.
3. Initial request must include laboratory results, ABG's and specify whether taken at rest, sleep or during exercise.

Portable Oxygen requires additional documentation.

See: **Durable Medical Equipment (DME)**

Appendix A
DME, Corrective Appliances, Medical Supplies and Surgical Implantables Grid

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Hospice Care

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51180)
(DHCS, MMCD All Plan Letter 07-014, Hospice Services and Medi-Cal Managed Care, Oct. 12, 2007)

Hospice care means the provision of palliative and supportive treatment and services to an individual who has been certified by a physician to be terminally ill and who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition. Eligible services include:

1. Nursing services;
2. Physical, occupational and speech-language pathology;
3. Medical social services under the direction of a physician;
4. Home health aide and homemaker services;
5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician services;
8. Short-term inpatient care for pain control or chronic symptom management, which cannot be managed in the home setting;
9. Counseling services related to the adjustment of the Member's approaching death;
10. Continuous nursing services on a 24-hour basis only during periods of crisis and only as necessary to maintain the Member at home;
11. Respite care provided on an intermittent non-routine and occasional basis for up to five consecutive days at a time;
12. Palliative items or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

Benefit Exclusion (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51349)

A patient who is being actively treated for the terminal illness cannot elect hospice services. Hospice services shall not be covered beyond 390 days.

Hospice Care (continued)

Examples of Covered Benefits

1. Nursing services when provided by or under the supervision of a registered nurse.
2. Counseling services when provided to the terminally ill individual and the family member or other persons caring for the individual at home.
3. Short-term inpatient care.
4. Home health aide services.
5. Respite care, only when provided in an inpatient facility, on an occasional, intermittent and non-routine basis and only when necessary to relieve family members or others caring for the terminally ill individual.
6. Drugs and biologicals when used primarily for the relief of pain and symptom control related to the individual's terminal illness.

Examples of Non-Covered Benefits

1. Patient is actively being treated for the terminal illness (e.g., a patient cannot continue receiving chemotherapy and elect hospice services).
2. Hospice services when the individual has not been certified as terminally ill in accordance with the procedures specified in Code of Federal Regulations, Title 42, Part 418, Subpart B.

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Hospital Services - Inpatient

Benefit Coverage

Inpatient hospital services are covered as specified in the California Code of Regulations, Title 22, Section 51327. These services include, but are not limited to, a semi-private room, intensive care, operating room, labor and delivery room, newborn care, anesthesia supplies, diagnostic lab and radiology, nuclear medicine, pharmacy, professional charges by the hospital-based pathologist or radiologist and other miscellaneous hospital charges related to medically necessary care and treatment.

Benefit Exclusion

Inpatient services related to non-emergency admissions when the required prior authorization is not obtained from the IPA.

Examples of Covered Benefits

1. Semi-private room.
2. ICU, CCU, PICU, NICU.
3. Meals and special diets (e.g., low fat, low cholesterol, low sodium).
4. Operating room/labor and delivery room/recovery room.
5. Drugs and medications.
6. Inhalation/Respiratory therapy.
7. Laboratory and Radiology services.
8. Physical Therapy.
9. Other hospital services, which are related to the patient's diagnosis and are, deemed medically necessary.

Examples of Non-Covered Benefits

1. Beds, cots, meals for guests and/or relatives.
2. Telephone charges.
3. Non-medically necessary hospitalization.
4. Late charges incurred due to patient convenience.
5. Surgical procedures performed on an inpatient basis, which can be performed safely on an outpatient, or ambulatory basis, will not be paid when performed as an inpatient, unless specifically authorized as an inpatient procedure.

Hospital Services - Inpatient (continued)

Examples of Non-Covered Benefits (continued)

6. Convenience items supplied by the hospital (shampoo, slippers, etc.).
7. Additional charges related to patient preferences:
    a. Private room.
    b. Television.
    c. Special meals not medically necessary.
    d. Private duty nursing.

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Hospital Services - Outpatient

Definitions (Medi-Cal Regulations – Cal. Code Regs., tit. 22, §§ 51112, 51113 & 51115)

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

"Hospital outpatient department services" mean diagnostic, preventive or therapeutic services furnished on an outpatient basis on the premises of a hospital.

"Organized outpatient clinic with surgical facilities" mean an organized outpatient clinic which conforms to the standards established in the California Code of Regulations, Title 22, Section 51115, subdivision (b).

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, §51331)

Hospital outpatient department services and organized outpatient clinic services, which include, but are not limited to, the services listed below, are covered. (Please see the California Code of Regulations, Title 22, Section 51331 for a complete list of services.)

1. Physician.
2. Laboratory and X-ray.
3. Hemodialysis.
4. Physical Therapy.
5. Speech Therapy.
6. Occupational Therapy.
7. Blood and Blood Derivatives.
8. Audiology.
9. Medical supplies.
10. Outpatient Surgery.
11. Use of an emergency, examination, or treatment room or other hospital facilities included in the California Code of Regulations, Title 22, Section 51509(g), when required for the provision of a covered physician's service.

<u>Hospital Services - Outpatient</u> (continued)

<u>Benefit Coverage</u> (continued)

Outpatient surgical procedures, other than those rendered as emergency services pursuant to the California Code of Regulations, Title 22, Section 51056, procedures considered to be elective, and specified outpatient medical procedures including, but not limited to, Hyperbaric Oxygen Therapy, Pheresis, Psoriasis Day Care and Cardiac Catheterization, require prior authorization by the contracted IPA.

All services performed in a hospital setting, with the exception of physician and medical supplies and emergency room charges (Cal. Code Regs., tit. 22, § 51056) generally require prior authorization per the contracted IPA procedure.

<u>Benefit Exclusion</u>

Services where required prior authorization has not been obtained, unless pre-approved, is not a covered benefit.

<u>Examples of Covered Benefits</u>

1. Medically necessary outpatient surgery.
2. Medically necessary outpatient diagnostic studies.
3. Radiation therapy.
4. Chemotherapy.
5. Outpatient blood transfusion.
6. Short-term rehabilitative therapy (e.g., Physical Therapy, Occupational Therapy, Respiratory Therapy).
7. Outpatient diagnostic testing (e.g., EEG, EKG, EMG, stress test).

<u>Examples of Non-Covered Benefits</u>

1. Non-medically necessary outpatient surgery.
2. Non-authorized elective outpatient surgery.
3. Long term rehabilitation therapy.
4. Experimental Treatment.
5. Cosmetic surgery (See: Cosmetic Surgery, Reconstructive Surgery).

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Human Immunodeficiency Virus (HIV) Testing

See: **Acquired Immune Deficiency Syndrome (AIDS)**