CA

51305 Physician Services

(a)

Outpatient physician services are covered if they are medically necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, subject to the limitations specified below.

(b)

Outpatient surgical procedures, other than those needed for diagnostic purposes or those rendered as emergency services pursuant to Section 51056; procedures considered to be elective; and specified outpatient medical procedures, including but not limited to, Hyperbaric Oxygen Therapy, Pheresis, Psoriasis Day Care and Cardiac Catheterization, require prior authorization. Authorization may be granted only when fully documented medical justification is provided that the services are medically necessary. Services not requiring prior authorization are subject to other utilization controls, as specified in this chapter. Utilization controls shall be imposed on medical/surgical procedures in accordance with the standards set forth in Section 51159. Identification of those procedures requiring prior authorization shall be transmitted to all affected providers of service in bulletins authorized by the Department.

(c)

Surgical procedures typically performed on an inpatient basis which can be performed safely on an outpatient or ambulatory basis will not be reimbursed in an inpatient setting. Exceptions may be authorized by a field office medical consultant if there is adequate documentation of the medical need for inpatient care. In selecting procedures which should normally be performed in an outpatient setting, the Department shall consider patient safety, quality of medical care, common practice in the medical community, and cost of the procedure. Lists of surgical procedures identified by the Department for performance on an outpatient or ambulatory basis will be transmitted to all interested providers of service in bulletins authorized by the Department.

(d)

A maximum of eight injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies may be provided in any 120-day period without prior authorization. Prior authorization shall be required when more than eight of the above allergy injections are provided in a 120-day period except those provided on an emergency basis.(1) Services rendered on an emergency basis are exempt from authorization. The emergency services shall meet the definition in Section 51056 and the provider shall comply with the requirements of that section. (2) A total treatment plan shall be developed for allergy services which require prior authorization. The treatment plan may be authorized for a period up to 120 days and shall include the following: (A) The principal diagnosis and significant associated diagnosis. (B) Clinical information adequate to describe the physiological and functional limitations, including the date of onset of the illness(es). (C) Prognosis. (D) Specific services to be rendered. (E) The therapeutic goals to be achieved and the anticipated time needed to attain those goals. (F) Drug regimen.

(1)

Services rendered on an emergency basis are exempt from authorization. The emergency services shall meet the definition in Section 51056 and the provider shall comply with the requirements of that section.

(2)

A total treatment plan shall be developed for allergy services which require prior authorization. The treatment plan may be authorized for a period up to 120 days and shall include the following: (A) The principal diagnosis and significant associated diagnosis. (B) Clinical information adequate to describe the physiological and functional limitations, including the date of onset of the illness(es). (C) Prognosis. (D) Specific services to be rendered. (E) The therapeutic goals to be achieved and the anticipated time needed to attain those goals. (F) Drug regimen.

(A)

The principal diagnosis and significant associated diagnosis.

(B)

Clinical information adequate to describe the physiological and functional limitations, including the date of onset of the illness(es).

(C)

Prognosis.

(D)

Specific services to be rendered.

(E)

The therapeutic goals to be achieved and the anticipated time needed to attain those goals.

(F)

Drug regimen.

(e)

Physician services provided to hospital, skilled nursing facility or intermediate care facility inpatients are covered only during periods of hospital, skilled nursing facility or intermediate care facility stays covered by the program.

(f)

Psychiatry, psychology, physical therapy, occupational therapy, audiology, speech therapy, optometry and podiatry services are not covered as physicians' services when performed by persons other than physicians.

(g)

Respiratory care is covered as a physician service. Respiratory care is subject to prior authorization except when personally rendered by the physician. Authorization requests shall include clinical justification for the services and the nature, frequency and expected duration of the respiratory care.

(h)

Orthoptics and pleoptics are not covered.

(i)

Procedures for the treatment of defects for cosmetic purposes only are covered subject to prior authorization. Authorization may be granted only for the correction of serious disfigurement eligible for coverage by California Children Services. These patients shall be referred to that program as provided in Section 51013.

(j)

A second eye examination with refraction within twenty-four months is covered only when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date of any prior eye examination with refraction.

(k)

Primary care physician services rendered by nonphysician medical practitioners are covered as physician's services to the extent permitted by applicable professional licensing statutes and regulations, and as set forth in the Physician-Practitioner Interface as described in Section 51240. (1) Services and entries in the patient's health record by nonphysician medical practitioners shall be reviewed by the primary care physician to the extent required by the applicable professional licensing statutes and regulations. (2) Patients shall be informed or notified in writing, prior to being served, that medical services may be rendered by nonphysician medical practitioners. In cases of emergencies as defined in Section 51056, the nonphysician medical practitioner may render emergency services to a patient without such prior notification. (3) Reimbursement for services rendered by nonphysician medical practitioners shall be made in accordance with Section 51503.1. (4) Reimbursement shall not be made for service rendered by a nonphysician medical practitioner to a person eligible for Medicare benefits unless Medicare makes reimbursement for that service by that practitioner. (5) Out-of-State services of nonphysician medical practitioners are covered in accordance with each of the following: (A) The Medicaid law and program for that location. (B) Local laws applicable to such practitioners. (C) The provisions of Section 51006.

(1)

Services and entries in the patient's health record by nonphysician medical practitioners shall be reviewed by the primary care physician to the extent required by the applicable professional licensing statutes and regulations.

(2)

Patients shall be informed or notified in writing, prior to being served, that medical services may be rendered by nonphysician medical practitioners. In cases of emergencies as defined in Section 51056, the nonphysician medical practitioner may render emergency services to a patient without such prior notification.

(3)

Reimbursement for services rendered by nonphysician medical practitioners shall be made in accordance with Section 51503.1.

(4)

Reimbursement shall not be made for service rendered by a nonphysician medical practitioner to a person eligible for Medicare benefits unless Medicare makes reimbursement for that service by that practitioner.

(5)

Out-of-State services of nonphysician medical practitioners are covered in accordance with each of the following: (A) The Medicaid law and program for that location. (B) Local laws applicable to such practitioners. (C) The provisions of Section 51006.

(A)

The Medicaid law and program for that location.

(B)

Local laws applicable to such practitioners.

(C)

The provisions of Section 51006.

(l)

External mammary prostheses made of silicone or other similar materials, prosthetic mammary implants, and reconstructive mammoplasty shall be deemed medically necessary incident to mastectomy and shall be covered. "Mastectomy" means the surgical procedures as described in the latest edition of the Physicians' Current Procedural Terminology for the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon who is a Department Medi-Cal consultant.

(m)

One early discharge follow up visit is covered without prior authorization when the requirements of Section 51327(b) are met.