



An Advocate's Guide to Medi-Cal Services

December 2022

Chapter XII: Ancillary Services

Chapter XII: Ancillary Services

Outline of Medi-Cal Ancillary Services Covered in this Chapter*

- Therapies and Other Professional Services
 - Physical Therapy
 - Occupational Therapy
 - Respiratory Therapy
 - Audiology
 - Speech Therapy
 - Vision Services
 - Acupuncture
 - Chiropractic Services
- Transportation
 - Emergency medical transportation
 - Nonemergency medical transportation
 - Nonmedical transportation
 - Air transportation (under certain circumstances)
- Diagnostic Tests
 - Laboratory services
 - Imaging services
- Other Specialized Services
 - Dialysis
 - Transplants

*This is a non-exhaustive list of services. It may not include all available services.

Medi-Cal covers many different services that fall outside the traditional categories of hospital, medical, and nursing services. These services often fall under optional coverage categories under federal Medicaid law. In 2009, due to budgetary concerns, California eliminated coverage of several categories of such services for adults, including audiology services, speech therapy, and acupuncture. As the economy recovered, the State restored coverage of many of these services. In addition, litigation has impacted Medi-Cal's coverage of certain services, including nonmedical transportation (NMT), which was added as a covered benefit for adults in 2017 following years of legal challenges.

A. Therapies and Other Professional Services

1. Physical Therapy, Occupational Therapy, and Respiratory Therapy

Medi-Cal covers physical therapy, occupational therapy, and respiratory therapy for children and adults. Physical therapy and occupational therapy involve the provision of rehabilitative and habilitative care, but the services differ in their respective treatment goal. Medi-Cal coverage of physical therapy is “limited to treatment immediately necessary to prevent or to reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.”¹ In contrast, the purpose of occupational therapy is “to restore or improve a person’s ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced age.”² Thus, while physical therapy aims to prevent or treat injuries, occupational therapy aims to improve an individual’s ability to engage in daily activities such as eating, bathing, and getting dressed.

Respiratory therapy is available for Medi-Cal beneficiaries to treat deficiencies in the pulmonary (respiratory) system. These services include administration of medical gases, pharmacologic agents related to respiratory care procedures, mechanical or physiological ventilator support, bronchopulmonary hygiene, cardiopulmonary resuscitation, maintenance of natural airways, insertion (without cutting tissues) and maintenance of artificial airways, diagnostic and testing techniques required for implementation of respiratory care protocols, and collection and analysis of blood specimens and specimens from the airway tract.³

In order to access physical, occupational, or respiratory therapy through Medi-Cal, beneficiaries must have a prescription. For physical therapy and occupational therapy, the prescription can be from a physician, dentist, or podiatrist.⁴ For respiratory care services, the prescription must be from a physician or surgeon.⁵ All prescriptions must specifically describe the services and include the frequency, duration, and therapeutic goal of the therapy prescribed, among other requirements.⁶

Medi-Cal coverage of physical, occupational, and respiratory therapy services may be subject to prior authorization. For physical therapy, prior authorization is always required for children and adult beneficiaries alike.⁷ Prior authorization requests for physical therapy are approved when the service requested is necessary to prevent or substantially reduce an anticipated hospital stay, continues a plan of treatment initiated in the hospital, or is recognized as a logical component of post-hospital care. Beneficiaries under 21, however, continue to be subject to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical necessity criteria. Therefore, physical therapy services are required to be provided for beneficiaries under 21 when the services are necessary to correct or ameliorate an identified condition.

For occupational therapy, initial and six-month evaluations do not require prior authorization, but all other coverage requests do.⁸ Initial respiratory therapy evaluations are not subject to prior authorization. Because Medi-Cal covers respiratory therapy services as physician services, subsequent respiratory therapies do not require prior authorization if performed by a physician, or by a respiratory therapist or a nurse (trained in respiratory treatment administration), or staff under physician supervision, as long as the physician is present during the procedure.⁹ Finally, coverage of occupational therapy services for adults is limited to two visits per month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.¹⁰

2. Audiology, Speech Therapy, and Podiatry

Medi-Cal covers audiology services, speech therapy services, and podiatry services as outpatient services.¹¹ Specifically, the program covers these services as physician services when rendered by physicians and as rehabilitation center outpatient services when rendered by persons other than physicians at rehabilitation centers.¹² Rehabilitation centers are facilities that “provide an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.”¹³

Audiology services include “the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids.”¹⁴ Medi-Cal covers audiology services only if the beneficiary has obtained a written referral from a physician or dentist and if the services are provided by an audiologist licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which they practice.¹⁵

Medi-Cal covers speech therapy services only if the beneficiary has obtained a written referral from a physician or dentist and if the services are provided by a speech pathologist licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which they practice.¹⁶ For adults, coverage of speech therapy extends to the following components:

- Evaluation of participants and development of necessary plans for appropriate speech and language therapy
- Instruction of other health team personnel and family members in methods of assisting the participant to improve and correct speech disorders

Medi-Cal covers podiatry services when provided by podiatrists licensed to practice podiatry by the California Board of Medical Quality Assurance or

similarly licensed by a comparable agency of the state in which they practice.¹⁷ These services are covered as part of an evaluative office visit if they are necessary to either treat disorders of the feet, ankles, or tendons that insert into the foot, or to treat a disease that significantly impairs the ability to walk.¹⁸ Medi-Cal coverage, however, does not extend to routine nail trimming.¹⁹ Prior authorization of podiatry services is required if the service involves anything other than an evaluative office visit.²⁰

Coverage for all these services is subject to certain restrictions, although for beneficiaries under 21, all services must be made available without restrictions as long as they are needed to correct or ameliorate an identified condition under the EPSDT benefit. Coverage for audiology, speech therapy, and podiatry services for adults is limited to two visits per month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.²¹ This restriction applies to any combination of such services. For example, if an adult beneficiary receives both a speech therapy and an audiology service in a given month, the beneficiary may not obtain coverage of a podiatric service until the following month.

3. Hearing Aids and Cochlear Implants

In addition to the services of audiologists, Medi-Cal also covers hearing aids. In order to obtain coverage for a hearing aid, a beneficiary must:²²

- Undergo a complete ear, nose, and throat examination by an otolaryngologist (or the attending physician if an otolaryngologist is not available);
- Obtain a prescription from an otolaryngologist (or from the attending physician); and
- Undergo a hearing aid assessment performed by the dispensing practitioner, who may be a physician, an audiologist, or a hearing aid dispenser.

In addition, Medi-Cal imposes an annual \$1,510 hearing aid cap per beneficiary.²³ This cap, however, does not apply to pregnant women who are seeking the hearing aid for a condition related to the pregnancy, children under 21 pursuant to the EPSDT mandate, and residents of skilled nursing facilities or intermediate care facilities.²⁴ Beneficiaries can obtain two hearing aids – one for each ear – so long as the total cost falls below \$1,510. If the cost of the hearing aid(s) exceeds \$1,510, the hearing aid vendor is prohibited from billing the beneficiary for the difference. Instead, the vendor must either provide a hearing aid(s) that costs less than \$1,510 or provide the more expensive hearing aid(s) and accept any financial loss.²⁵ By law, the vendor cannot bill a beneficiary if it accepts Medi-Cal payment for the service.²⁶

Medi-Cal also covers cochlear implants. These implants differ from hearing aids in that they do not only amplify sound but also deliver sound signals to the

auditory nerve and bypass damaged portions of the ear and therefore have to be surgically implanted. For this reason, Medi-Cal typically provides coverage for such implants to individuals with severe hearing loss who do not hear properly even after receiving a hearing aid. Since cochlear implants are more expensive than hearing aids, Medi-Cal has strict criteria regarding who may receive such implants. Among other requirements, Medi-Cal will only authorize coverage of a cochlear implant if the candidate or caregiver is willing to undergo a program of training and long-term rehabilitation since it takes significant training and effort to learn to use such an implant.²⁷

In certain circumstances, replacement of and repairs for hearing aids are also covered. Under state law, hearing aid suppliers must guarantee the hearing aid for at least one year, meaning they have to repair or replace the hearing aid if it or some of its parts become defective within a year after the beneficiary receives the aid (the guarantee does not apply to the earpiece, cord, or batteries).²⁸ If the guarantee period has expired, then repair of the hearing aid or replacement of the hearing aid (or just parts of the hearing aid) may be covered by Medi-Cal. However, replacement batteries are not covered for adults; beneficiaries needing new batteries must purchase the batteries on their own. Moreover, the cost of repair and replacement is subject to the \$1,510 cap unless the beneficiary can show that the hearing aids were lost, stolen, or irreparably damaged based on events beyond the beneficiary's control. If the hearing aid was stolen, for example, the beneficiary may need to provide a copy of the police report to document the theft.²⁹

Medi-Cal also covers repairs and replacement of cochlear implants, although prior authorization is required for many replacement supplies, such as headset/headpiece, microphone, transmitting coil, transmitter cable for use with cochlear implant, auditory osseointegrated device, and external speech processor and controller.³⁰ Unlike with hearing aids, Medi-Cal pays for replacement batteries for cochlear implants subject to prior authorization.

Finally, to conform with EPSDT requirements, federal law requires states must provide hearing screenings to children at "intervals which meet reasonable standards of medical practice" and at other intervals that are medically necessary to determine the existence of a suspected illness or condition.³¹ California has adopted the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule, which requires hearing screenings at birth, at two months, and regularly thereafter.³² Medi-Cal must also cover all treatments necessary to address conditions discovered during hearing screenings, including hearing aids and cochlear implants.³³ As noted above, the \$1,510 cap on coverage of hearing aids and the prohibition on coverage of audiology services does not apply to children. In addition, children can obtain coverage of replacement hearing aid batteries on a quarterly basis without prior authorization.³⁴

4. Vision Services

Medi-Cal covers some vision services related to the health of the eye under the mandatory category of physician services. All adult beneficiaries may receive routine eye exams to check the health of their eyes once every 24 months. A second eye exam is covered within the 24-month period only when a sign or symptom indicates a need for another exam.³⁵ In addition, services provided by ophthalmologists acting within the scope of their practice also fall within the mandatory physician services category.

California has also elected to cover vision services, an optional benefit under federal law, for adult beneficiaries in most circumstances.³⁶ Along with ophthalmologist services, Medi-Cal also covers services provided by optometrists acting within the scope of their practice. These services include vision exams, the fitting of and prescription for eyeglasses and contact lenses, and diagnosis, treatment, and management of certain eye diseases and disorders of the eye, as well as related systemic conditions.³⁷ As with eye exams, vision tests with refraction to determine the prescription strength for glasses and/or contact lenses are limited to once per 24 months, except when a sign or symptom indicates a need for additional services.³⁸

Since 2020, Medi-Cal has provided coverage for eyeglasses and contact lenses when prescribed by an ophthalmologist or optometrist. Prescription lenses are covered when the prescription is for one of the following:

- Single vision lenses;
- Multifocal lenses;
- Replacement single or multifocal lenses;
- Absorptive lenses, which reduce the amount of light energy reaching the eye;
- Trifocal lenses for beneficiaries who are currently wearing trifocals; and
- Single balance lens (other balance lenses are covered only when medically justified).

Coverage for prescription eyeglass frames is limited to one pair every two years, but beneficiaries can receive a replacement of frames lost, stolen, or destroyed in circumstances beyond the beneficiary's control within that two-year period.³⁹ Replacement for frames for other reasons may be covered if the provider submits a statement explaining why the prior frame should be replaced.⁴⁰ Replacement of frames within two years is always limited to the same frame model whenever feasible.⁴¹

In general, Medi-Cal covers contact lenses with a prescription only if the use of eyeglasses is not an option.⁴² The following chart summarizes Medi-Cal coverage of contact lenses and whether prior authorization is required for each circumstance:

| Prior Authorization Required | No Prior Authorization Required |
|---|--|
| Extended wear contact lenses and disposable contact lenses designed for short-term wear and frequent replacement if other lenses cannot be used | Contact lenses for a diagnosis of aphakia or keratoconus when contact lenses other than extended wear lenses are fitted |
| Contact lenses when chronic pathology or deformity of the nose, skin, or ears precludes the use of glasses | Contact lenses when eyeglasses are contraindicated due to chronic corneal or conjunctival pathology or deformity other than corneal astigmatism when contact lenses other than extended wear lenses are fitted |
| Contact lenses for a diagnosis of aniseikonia when supported by clinical data | Therapeutic bandage lenses prescribed by a physician for a diagnosis approved by the federal Food and Drug Administration for those lenses, when fitted by a physician or by a dispensing optician or optometrist under the supervision of a physician |

Medi-Cal also provides coverage for optical aids and prosthetic eyes. Beneficiaries can receive low vision optical aids if the aids help to markedly enhance visual function and if all of the following conditions are met: the condition causing subnormal vision is chronic and cannot be treated by medical or surgical intervention; the physical and mental condition of the beneficiary is such that there is reasonable expectation that the aid will be used to enhance everyday functioning; and the aid prescribed is the least costly type that will meet the beneficiary's needs.⁴³ In addition, when the amount claimed for payment of a low vision optical aid is \$100 or more, prior authorization is required.⁴⁴ Finally, prosthetic or artificial eyes are covered for beneficiaries who have lost an eye or eyes due to disease or injury if the beneficiary has obtained a written prescription from a physician or an optometrist.⁴⁵ Replacement of artificial eyes is covered to prevent a significant disability when the prior eye was lost or destroyed due to circumstances beyond the beneficiary's control, when the prior eye can no longer be rehabilitated, or to accommodate changes in orbital development in children under 18.⁴⁶

As with hearing services, coverage of vision services for children is more robust than it is for adults due to the EPSDT benefit. Medi-Cal uses the same AAP periodicity schedule for vision as it does for hearing services. Under the

periodicity schedule for vision, beneficiaries under 21 must be screened for visual problems at each health assessment visit.⁴⁷ Moreover, federal law requires vision screenings that meet reasonable standards of medical practice at intervals that are medically necessary to determine the existence of a suspected illness or condition.⁴⁸ As a result, if a beneficiary under 21 needs additional vision exams within two years, Medi-Cal would cover these exams under the EPSDT benefit. Federal law also mandates coverage of eyeglasses for Medicaid beneficiaries under 21 who need them, so any state-imposed limitation on coverage of eyeglasses has no impact on the ability of children to receive this service.⁴⁹

5. Acupuncture

Largely in response to the opioid overdose epidemic, in 2016, California restored Medi-Cal coverage of acupuncture services, which had been eliminated as part of the 2009 budget cuts.⁵⁰ Acupuncture represents a treatment alternative to the use of prescription opioids to treat chronic pain.

Under Medi-Cal, acupuncture is the “stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent, modify or alleviate” the perception of pain.⁵¹ Acupuncture can be provided by an acupuncturist or a physician, dentist, or podiatrist.⁵² Medi-Cal covers acupuncture either with or without electrical stimulations of the needles.⁵³ However, acupuncture is only covered if the perceived pain is severe, persistent, or chronic and results from a generally recognized medical condition. Moreover, acupuncture is covered only when used to treat a condition for which treatment by other modalities is also covered.⁵⁴

A beneficiary does not need a prescription for acupuncture, nor does a beneficiary typically need to obtain prior authorization.⁵⁵ Coverage of acupuncture services for adults is limited to two visits per month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.⁵⁶ However, for managed care beneficiaries, additional services can be provided based upon medical necessity subject to the Managed Care Plan (MCP) prior authorization process.⁵⁷ Importantly, pursuant to federal law, there is no frequency limitation for beneficiaries under 21 receiving services pursuant to EPSDT.

6. Chiropractic Services

Chiropractic services are services provided by chiropractors acting within the scope of their practice as authorized by California law. Chiropractic services have been excluded from Medi-Cal coverage under California law.⁵⁸ However, this coverage exclusion does not apply in the following situations:

- Services are provided as emergency procedures.⁵⁹

- The beneficiary is pregnant, and the services relate to the pregnancy.⁶⁰
- The beneficiary is a minor under 21 and covered under the EPSDT benefit.⁶¹
- The beneficiary resides in a skilled nursing facility or an intermediate care facility.⁶²
- The services are provided in a Medi-Cal acute inpatient hospital; in an out-of-state inpatient hospital and other facilities when the service is included in the all-inclusive rate; in a hospital outpatient department and hospital outpatient clinic; or in emergency rooms for acute inpatient hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).⁶³

In addition, Medi-Cal coverage of chiropractic services extends only to treatment of the spine by means of manual manipulation.⁶⁴ Manual devices – that is, devices that are handheld with the thrust of the force of the device being controlled manually – may be used for provision of the service, but Medi-Cal coverage does not extend to the cost of the device itself.⁶⁵ Finally, coverage of outpatient chiropractic services for adults is limited to two visits per month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy.⁶⁶

B. Transportation

Federal Medicaid law requires state Medicaid programs to ensure that beneficiaries have sufficient transportation to access medical care.⁶⁷ Transportation plays an important role in facilitating access to care. In California, to ensure Medi-Cal beneficiaries can access covered Medi-Cal services, the State covers three different types of transportation: emergency transportation, nonemergency medical transportation (NEMT), and NMT. On a limited basis, Medi-Cal covers transportation via air, which can be provided on an emergency or nonemergency basis.

ADVOCACY TIP:

- ✓ Some services have a quantitative limit on coverage per month. Such services that are limited to two visits per month or a combination of two services per month are:
 - Acupuncture
 - Psychology
 - Physical therapy
 - Occupational therapy
 - Speech pathology
 - Audiological
 - Podiatry
 - Prayer or spiritual healing
 - Hospital outpatient department services and organized outpatient clinic
- ✓ While quantitative limits can be placed on services for adults, remember that children and youth under 21 are entitled to all EPSDT-covered treatment or services necessary to correct or ameliorate their illness or condition.

1. Emergency Medical Transportation

Medi-Cal covers emergency medical transportation in medical emergencies. Coverage for emergency medical transportation extends to transportation to the nearest hospital or acute care facility that meets the beneficiary's medical needs.⁶⁸ Typically, emergency transportation is made via ambulance, but it can occur via other means of transportation, such as via air.

Prior authorization is not required to access emergency medical transportation. However, there are certain Medi-Cal billing requirements. Transportation providers must produce an emergency statement for each emergency medical transportation Medi-Cal claim they submit for reimbursement.⁶⁹ Medi-Cal will also only cover the lowest-cost type of medical transportation that meets the individual's medical needs.⁷⁰

2. Nonemergency Medical Transportation (NEMT)

NEMT is transportation of Medi-Cal beneficiaries by ambulance, wheelchair van, or litter van to get to and from providers furnishing covered Medi-Cal services. Medi-Cal covers NEMT only when the beneficiary's medical and physical condition is such that ordinary means of private transportation, such as bus, passenger car, or taxicab, is contraindicated.⁷¹ For example, NEMT is often approved for beneficiaries who cannot walk or stand without assistance from a wheelchair, walker, or crutches. Medi-Cal will cover only the lowest-cost transportation that meets the beneficiary's needs.⁷²

Physician decisions regarding NEMT must be unhindered by fiscal and administrative management.⁷³ MCPs must ensure that providers make decisions about NEMT based solely on medical necessity and with no regard to fiscal or administrative constraints. MCPs must make sure there are no limits to covering NEMT, as long as the NEMT has prior authorization and the beneficiary's services are medically necessary.⁷⁴ The transportation provider must ensure door-to-door assistance from the point of departure to the destination.⁷⁵ If the beneficiary is a minor, then the provider must also cover transportation of the minor's parent or guardian. A minor traveling to a "minor consent" service, i.e., a service to which the minor can provide consent without the knowledge of the parent or guardian, does not need written consent to travel alone.⁷⁶

Authorization Requirements

Unlike emergency medical transportation, NEMT services require prior written authorization by a licensed physician, dentist, podiatrist, or mental health or substance use disorder (SUD) provider. The provider must submit a treatment authorization request (TAR) for the NEMT services. Prior authorization is not required, however, when an individual is being discharged from a hospital

immediately following an inpatient stay at the acute level of care to a skilled nursing facility or intermediate care facility.⁷⁷

The authorization requirements for NEMT are the same for beneficiaries enrolled in fee-for-service (FFS) and in Medi-Cal MCPs. Medi-Cal MCP providers must submit NEMT requests directly to their plans, while FFS providers must submit TARs to the Department of Health Care Services (DHCS) directly.⁷⁸ A Medi-Cal MCP must also make its best effort to refer for and coordinate NEMT for all Medi-Cal services not covered by the MCP contract, such as specialty mental health, SUD, dental, and any other services through the FFS delivery system.⁷⁹ MCPs may use prior authorization to reauthorize NEMT every 12 months when necessary to avoid duplicative paperwork and ensure consumers have expedient access to ongoing care.⁸⁰

3. Nonmedical Transportation (NMT)

NMT is round-trip transportation to access covered Medi-Cal services. NMT is provided by public conveyance—such as taxis, buses, trains, and rideshare apps such as Uber and Lyft—and transportation via private conveyance, such as a friend driving a beneficiary in the friend’s car.⁸¹ NMT also covers mileage reimbursement.⁸² NMT does not include transportation of the sick, injured, or infirm, or those who otherwise need to be transported by ambulance, litter van, or wheelchair van. NMT is available to travel to medically necessary appointments, to pick up prescriptions that cannot be mailed directly to the beneficiary, to pick up durable medical equipment and other medical supplies, and to visit a sick child in the hospital.⁸³

NMT has long been a benefit when provided as an EPSDT service.⁸⁴ However, in 2016, the Governor signed AB 2394, which clarified that NMT is a Medi-Cal benefit as of July 1, 2017, for both adults and children.⁸⁵ Further, effective October 1, 2017, Medi-Cal MCPs must also provide NMT for Medi-Cal services that are carved out of the plan, such as specialty mental health services (SMHS), SUD services, dental services, and any other services furnished through the FFS delivery system.⁸⁶

NMT is subject to many of the same rules as NEMT:

- NMT is only covered if the beneficiary is traveling to or from a Medi-Cal-covered service.⁸⁷ For beneficiaries in managed care, NMT is covered if the beneficiary is traveling to a service that is covered either by the MCP or by FFS Medi-Cal (i.e., the service is carved out of managed care coverage).⁸⁸
- In the case of minors, NMT can include transportation of the minor’s parent or guardian.⁸⁹
- There are no mileage restrictions on the use of NMT.

Authorization Requirements: Managed Care Plan Versus Fee-for-Service

Unlike NEMT, a Medi-Cal beneficiary does not need a prescription to obtain NMT.⁹⁰ However, beneficiaries using NMT must attest that other available transportation resources have been reasonably exhausted.⁹¹ While MCP enrollees submit attestations to their MCP, FFS beneficiaries must submit attestations to DHCS.

Medi-Cal MCPs have some discretion to set their own prior authorization rules for their enrollees, so MCP enrollees should contact their MCP to access this benefit.⁹² MCPs may use prior authorization to reauthorize NMT every 12 months when necessary to avoid duplicative paperwork and ensure consumers have expedient access to ongoing care.⁹³ As with NEMT, beneficiaries in FFS Medi-Cal must request NMT directly from DHCS.⁹⁴

4. Air Transportation

Medi-Cal may cover air transportation in either an emergency or nonemergency situation, but this is a limited benefit given the high cost of such transportation. For emergencies, Medi-Cal covers air transportation if the medical condition of the beneficiary precludes the use of other transportation or if the beneficiary, or the hospital that is the beneficiary's destination, is inaccessible via ground transportation.⁹⁵ Emergency air transportation is provided without authorization inside California and to specific border communities in Arizona, Nevada, and Oregon, but authorization is required for transportation to other states.⁹⁶

In nonemergencies, Medi-Cal covers air transport only when the medical condition of the beneficiary requires such transport or if practical considerations render ground transportation infeasible. Coverage for nonemergency air transport is only available if a physician, podiatrist, or dentist has ordered such transportation.⁹⁷

C. Diagnostic Tests

Laboratory and imaging services are mandatory Medicaid services and, therefore, are covered services under Medi-Cal.⁹⁸

Covered laboratory tests include, but are not limited to:⁹⁹

- Blood counts
- Cholesterol tests
- Cytopathology
- Drug tests
- Glucose tests
- Hemoglobin tests
- Hepatitis screenings
- Human immunodeficiency virus (HIV) screenings

- Human papillomavirus (HPV) screenings
- Infectious agent detection by nucleic acid (DNA or RNA)
- Oncology screenings
- Pregnancy tests
- Uric acid tests

Covered imaging includes, but is not limited to:¹⁰⁰

- Computed tomography (CT)
- Dual-energy X-ray absorptiometry (DXA)
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Magnetic resonance angiography (MRA)
- Magnetic resonance cholangiopancreatography (MRCP)
- Magnetic resonance imaging (MRI)
- Mammography
- Positron emission tomography (PET)
- Ultrasound
- X-rays

Many of these types of imaging require prior authorization.¹⁰¹

Medi-Cal also covers portable imaging services under certain circumstances. Under the portable imaging benefit, the imaging equipment is brought to a location, such as a beneficiary's home or a nursing home. However, Medi-Cal prohibits coverage of certain procedures and examinations via portable imaging. For example, fluoroscopy and procedures requiring the administration of a substance to the beneficiary are not covered if provided through portable imaging.¹⁰² In addition, in order to prevent unfair competition, Medi-Cal does not cover portable imaging services if the provider ordering the imaging services has a financial interest in the portable imaging services provider.¹⁰³

D. Other Specialized Services

1. Dialysis

Medi-Cal covers dialysis, which is the removal by artificial means of waste products normally excreted by the kidneys.¹⁰⁴ Dialysis is used to treat people with kidney failure or end-stage renal disease (ESRD).

Dialysis may be provided in renal dialysis centers, community hemodialysis units, or a beneficiary's home. Coverage for this service is subject to prior authorization, which may be granted for up to 12 months at a time.¹⁰⁵ If a beneficiary seeks to receive home dialysis, the beneficiary's providers must submit evidence of the following:¹⁰⁶

- The beneficiary, the beneficiary's spouse, or other co-learner is suitable for training on in-home dialysis;
- The home facilities are suitable for dialysis;

- The overall installation costs in the home are reasonable and in no event exceed \$750;
- The water supply in the home is suitable for renal dialysis;
- A qualified local physician is available for the ongoing medical supervision of the beneficiary;
- There is a plan for continuing case management; and
- There is a budget for all expenses related to home dialysis, including supplies prorated on a monthly cost basis, and the costs to install dialysis equipment in the home will be less than \$750.

2. Transplants

Medi-Cal coverage of organ and bone marrow transplants extends to the surgery to remove the organ from a donor, the transplant surgery, and antirejection medications following the transplant surgery.¹⁰⁷ Covered transplants include:¹⁰⁸

- Bone marrow (stem cell)
- Heart
- Heart-lung
- Kidney
- Liver
- Small bowel
- Combined liver/small bowel
- Lung
- Simultaneous kidney-pancreas
- Pancreas

Authorization is required for major solid organ, autologous islet cell, and bone marrow transplants.¹⁰⁹ Finally, Medi-Cal only covers transplants if the surgeries are performed at hospitals that are recognized by Medi-Cal as centers of excellence for the specific organ transplant involved.¹¹⁰

Individuals often need to continue taking antirejection medication after a transplant. If the individual loses Medi-Cal eligibility during the period in which the individual is taking such medications, the loss of such eligibility may harm access to the antirejection medication and threaten the person's health. To address this situation, Medi-Cal provides continuing coverage for those on antirejection drugs for up to two years following a transplant if the person loses coverage during that time unless the person becomes eligible for other health insurance that would cover the medication.¹¹¹ Importantly, since the enactment of the Affordable Care Act (ACA), individuals who previously qualified for Medi-Cal coverage based on a disability may now be eligible for coverage under California's Medicaid expansion.

Endnotes

- ¹ CAL. CODE REGS. tit. 22, § 51309(b).
- ² CAL. CODE REGS. tit. 22, § 51085.
- ³ CAL. CODE REGS. tit. 22, § 51082.1.
- ⁴ CAL. CODE REGS. tit. 22, §§ 51081, 51085, 51309(a).
- ⁵ CAL. CODE REGS. tit. 22, § 51316(a).
- ⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Physical Therapy* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/phys.pdf> [hereinafter *Medi-Cal Provider Manual, Physical Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Occupational Therapy* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/occu.pdf> [hereinafter *Medi-Cal Provider Manual, Occupational Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/respir.pdf> [hereinafter *Medi-Cal Provider Manual, Respiratory Care*].
- ⁷ CAL. CODE REGS. tit. 22, § 51309(d); *Medi-Cal Provider Manual, Physical Therapy*, *supra* note 6, at 2.
- ⁸ *Medi-Cal Provider Manual, Occupational Therapy*, *supra* note 6, at 4, <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/occu.pdf>.
- ⁹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care*, *supra* note 6, at 2.
- ¹⁰ CAL. CODE REGS. tit. 22, § 51304(a).
- ¹¹ CAL. WELF. & INST. CODE § 14132(a). As part of the 2009 budget cuts, California declined to cover audiology, speech therapy, and podiatry services for adult beneficiaries. CAL. WELF. & INST. CODE § 14131.10(b)(1)(C), (F). Beneficiaries under 21, pregnant women who needed these services in connection with their pregnancy, and residents of skilled nursing facilities and intermediate care facilities were exempted from this policy. CAL. WELF. & INST. CODE § 14131.10(b)(3), (c). In 2019, however, as part of the budget approval process, the State restored Medi-Cal coverage for audiology, speech therapy, and podiatry services for all adult beneficiaries beginning on January 1, 2020. CAL. WELF. & INST. CODE § 14131.10(h)(1). Effective July 27, 2021, the Legislature made audiology, speech therapy services, podiatric services, and incontinence creams and washes covered benefits under the Medi-Cal program. CAL. WELF. & INST. CODE § 14131.10(h)(2).
- ¹² CAL. CODE REGS. tit. 22, § 51305(f); CAL. CODE REGS. tit. 22, § 51314(a).
- ¹³ CAL. CODE REGS. tit. 22, § 51117.
- ¹⁴ CAL. CODE REGS. tit. 22, § 51098.

- ¹⁵ CAL. CODE REGS. tit. 22, § 51309(a); CAL. CODE REGS. tit. 22, § 51219. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Audiological Services* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/audio.pdf> [hereinafter *Medi-Cal Provider Manual, Audiological Services*].
- ¹⁶ CAL. CODE REGS. tit. 22, § 51309(a); CAL. CODE REGS. tit. 22, § 51202. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Speech Therapy*1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/speech.pdf>.
- ¹⁷ CAL. CODE REGS. tit. 22, §§ 51310(a), 51229. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Podiatry Services* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/podi.pdf> [hereinafter *Medi-Cal Provider Manual, Podiatry Services*].
- ¹⁸ CAL. CODE REGS. tit. 22, § 51310(a)(1). See also *Medi-Cal Provider Manual, Podiatry Services*, *supra* note 17, at 1.
- ¹⁹ CAL. CODE REGS. tit. 22, § 51310(b); *Medi-Cal Provider Manual, Podiatry Services*, *supra* note 17, at 1.
- ²⁰ CAL. CODE REGS. tit. 22, § 51310(a).
- ²¹ CAL. CODE REGS. tit. 22, § 51304(a).
- ²² CAL. WELF. & INST. CODE § 14133.16.
- ²³ CAL. WELF. & INST. CODE § 14131.05(c); see Cal. Dep't Health Care Servs., *Hearing Aid Benefit Cap & Benefit FAQs* (updated Jan. 28, 2022), <https://www.dhcs.ca.gov/services/Pages/HearingAidCapFAQ.aspx> [hereinafter *Hearing Aid Benefit Cap & Benefit FAQs*].
- ²⁴ CAL. WELF. & INST. CODE § 14131.05(d), (e).
- ²⁵ *Hearing Aid Benefit Cap & Benefit FAQs*, *supra* note 23.
- ²⁶ 42 C.F.R. § 447.15; CAL. WELF. & INST. CODE §§ 14019.3(d), 14019.4(a).
- ²⁷ *Medi-Cal Provider Manual, Audiological Services*, *supra* note 15, at 8.
- ²⁸ CAL. CODE REGS. tit. 22, § 51517(b)(1).
- ²⁹ *Hearing Aid Benefit Cap & Benefit FAQs*, *supra* note 23.
- ³⁰ *Medi-Cal Provider Manual, Audiological Services*, *supra* note 15, at 8.
- ³¹ 42 U.S.C. § 1396d(r)(4).
- ³² CAL. CODE REGS. tit. 22, § 51184(a)(1); Cal. Dep't Health Care Servs., *Periodicity Schedules* (updated March 8, 2022), <https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx>.
- ³³ CMS, *EPSDT—A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* 15 (2014), https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf
- ³⁴ CAL. CODE REGS. tit. 22, § 51340.1(c)(2).
- ³⁵ CAL. CODE REGS. tit. 22, § 51305(j).

- ³⁶ As part of the 2009 budget cuts, California declined to cover “optometric and optician services, including services provided by a fabricating optical laboratory” (glasses and contact lenses) for adult beneficiaries. CAL. WELF. & INST. CODE § 14131.10(b)(1)(D). As with chiropractic, audiology, speech therapy, and podiatry services, beneficiaries under 21, pregnant women who needed vision care in connection with their pregnancy, and residents of skilled nursing facilities and intermediate care facilities were exempted from this policy and could obtain optician and optometry services, including glasses and contact lenses when use of glasses was not possible due to an eye disease or condition. CAL. WELF. & INST. CODE § 14131.10(b)(3), (c). In 2017, the State restored Medi-Cal coverage for vision services for all adult beneficiaries pending legislative allocation of funding. CAL. WELF. & INST. CODE § 14131.10(g)(1)–(2). The approved Governor’s Budget for 2019–2020 allocated funding for vision services, allowing beneficiaries to access the services beginning on January 1, 2020. Vision benefits remain covered for those beneficiaries with full-scope Medi-Cal benefits. See Cal. Dep’t Health Care Servs., Medi-Cal Vision Benefits, <https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/VisionBenefits.aspx> (last visited Dec. 5, 2022).
- ³⁷ CAL. CODE REGS. tit. 22, § 51306(a). See also Cal. Dep’t Health Care Servs., *supra* note 36.
- ³⁸ CAL. CODE REGS. tit. 22, § 51306(c).
- ³⁹ CAL. CODE REGS. tit. 22, § 51317(d).
- ⁴⁰ CAL. CODE REGS. tit. 22, § 51317(d)(1).
- ⁴¹ CAL. CODE REGS. tit. 22, § 51317(d)(2).
- ⁴² CAL. CODE REGS. tit. 22, § 51317(e).
- ⁴³ CAL. CODE REGS. tit. 22, § 51317(f).
- ⁴⁴ CAL. CODE REGS. tit. 22, § 51317(f)(5).
- ⁴⁵ CAL. CODE REGS. tit. 22, § 51317(g); Cal. Dep’t Health Care Servs., *supra* note 36.
- ⁴⁶ CAL. CODE REGS. tit. 22, § 51317(g)(2).
- ⁴⁷ CAL. CODE REGS. tit. 22, § 51184(a); Cal. Dep’t Health Care Servs., *supra* note 32. See also Cal. Dep’t Health Care Servs., *Health Assessment Guidelines - Chapter 27: Vision* (2017), <https://www.dhcs.ca.gov/services/chdp/Documents/HAG/Chapter27.pdf>.
- ⁴⁸ 42 U.S.C. § 1396d(r)(2).
- ⁴⁹ 42 U.S.C. § 1396d(r)(2)(B).
- ⁵⁰ See 2016 Cal. Stat. ch. 30 (S.B. 833), §§ 28, 36.
- ⁵¹ CAL. CODE REGS. tit. 22, § 51074.5.
- ⁵² CAL. CODE REGS. tit. 22, § 51308.5(a).
- ⁵³ CAL. CODE REGS. tit. 22, § 51308.5(c).
- ⁵⁴ CAL. CODE REGS. tit. 22, § 51308.5(b), (d). See also Cal. Dep’t Health Care Servs.,

Medi-Cal Provider Manual, Acupuncture Services 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/acu.pdf> [hereinafter *Medi-Cal Provider Manual, Acupuncture Services*].

⁵⁵ *Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 54, at 2.

⁵⁶ CAL. CODE REGS. tit. 22, §§ 51304(a), 51308.5(a). *See also Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 54.

⁵⁷ *See* Cal. Dep't Health Care Servs., All Plan Letter 16-015 (Dec. 1, 2016), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-015.pdf>.

⁵⁸ CAL. WELF. & INST. CODE § 14131.10(b)(1)(C)..

⁵⁹ CAL. WELF. & INST. CODE § 14131.10(b)(2)(B).

⁶⁰ CAL. WELF. & INST. CODE § 14131.10(b)(3).

⁶¹ CAL. WELF. & INST. CODE § 14131.10(c)(1).

⁶² CAL. WELF. & INST. CODE § 14131.10(c)(2).

⁶³ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Chiropractic Services* 6 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/chiro.pdf> [hereinafter *Medi-Cal Provider Manual, Chiropractic Services*].

⁶⁴ CAL. CODE REGS. tit. 22, § 51308. *See also Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63, at 1.

⁶⁵ *Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63.

⁶⁶ CAL. CODE REGS. tit. 22, § 51304(a); *Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63, at 6.

⁶⁷ 42 C.F.R. § 431.53.

⁶⁸ CAL. CODE REGS. tit. 22, § 51323(b)(1).

⁶⁹ *Id.*

⁷⁰ CAL. CODE REGS. tit. 22, § 51323(b).

⁷¹ CAL. CODE REGS. tit. 22, § 51323(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Training 2022: Medical Transportation Services* 6 (2022), https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/workbook_mc-trans.pdf.

⁷² CAL. CODE REGS. tit. 22, § 51323(b).

⁷³ Cal. Dep't Health Care Servs., All Plan Letter 22-008 at 3 (May 18, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf> [hereinafter All Plan Letter 22-008].

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.* at 10.

⁷⁷ CAL. WELF. & INST. CODE § 14136.3; CAL. CODE REGS. tit. 22, § 51323(b)(2)(C).

- ⁷⁸ Cal. Dep't Health Care Servs., DHCS Transportation Services, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx> (last visited Dec. 8, 2022). FFS beneficiaries can access NEMT by emailing DHCSNMT@dhcs.ca.gov or going to the DHCS Transportation webpage to find the list of available NMT and NEMT providers.
- ⁷⁹ All Plan Letter 22-008, *supra* note 73, at 3, 7.
- ⁸⁰ *Id.* at 3. See also Cal. Dep't Health Care Servs., *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses Frequently Asked questions (FAQs)* 4 (V.4 May 18, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008-NEMT-NMT-FAQ.pdf> [hereinafter *NEMT and NMT FAQs*].
- ⁸¹ CAL. WELF. & INST. CODE § 14132(ad)(2)(A)(i); All Plan Letter 22-008, *supra* note 73, at 8.
- ⁸² All Plan Letter 22-008, *supra* note 73, at 8.
- ⁸³ *Id.*
- ⁸⁴ *Id.* at 1.
- ⁸⁵ CAL. WELF. & INST. CODE § 14132(ad)(9).
- ⁸⁶ All Plan Letter 22-008, *supra* note 73, at 2.
- ⁸⁷ *Id.* at 8.
- ⁸⁸ *Id.* at 2.
- ⁸⁹ *Id.* at 9.
- ⁹⁰ *See generally Id.*
- ⁹¹ CAL. WELF. & INST. CODE § 14132(ad)(2)(B); All Plan Letter 22-008, *supra* note 73, at 9. *See also NEMT and NMT FAQs, supra* note 80, at 4.
- ⁹² All Plan Letter 22-008, *supra* note 73, at 3, 9-10.
- ⁹³ *Id.* at 9. See also *NEMT and NMT FAQs, supra* note 80, at 6.
- ⁹⁴ Cal. Dep't Health Care Servs., *supra* note 78. FFS beneficiaries can access NMT by emailing DHCSNMT@dhcs.ca.gov or going to the DHCS Transportation webpage to find the list of available NMT and NEMT providers.
- ⁹⁵ CAL. CODE REGS. tit. 22, §, 51323(c)(1).
- ⁹⁶ Cal. Dep't Health Care Servs., *supra* note 71, at 21.
- ⁹⁷ CAL. CODE REGS. tit. 22, § 51323(c)(2).
- ⁹⁸ CAL. CODE REGS. tit. 22, § 51311(a).
- ⁹⁹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pathology: Billing and Modifiers* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pathbil.pdf>.
- ¹⁰⁰ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Radiology: Diagnostic* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/>

[masters-mtp/part2/radidia.pdf](#).

¹⁰¹ For more information on prior authorization requests, see Cal. Dep't Health Care Servs., Treatment Authorization Request, <https://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx> (last visited March 23,2021).

¹⁰² CAL. CODE REGS. tit. 22, § 51311(c).

¹⁰³ CAL. CODE REGS. tit. 22, § 51311(d)(1).

¹⁰⁴ CAL. CODE REGS. tit. 22, § 51157(a).

¹⁰⁵ CAL. CODE REGS. tit. 22, § 51330(b).

¹⁰⁶ CAL. CODE REGS. tit. 22, § 51330(c).

¹⁰⁷ CAL. WELF. & INST. CODE § 14132.69(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transplants 1* (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf> [hereinafter *Medi-Cal Provider Manual, Transplants*].

¹⁰⁸ *Medi-Cal Provider Manual, Transplants*, *supra* note 107, at 1.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* See also CAL. WELF. & INST. CODE § 14132.71(a) (requiring DHCS to establish standards for facilities that provide transplants).

¹¹¹ CAL. WELF. & INST. CODE § 14132.70.