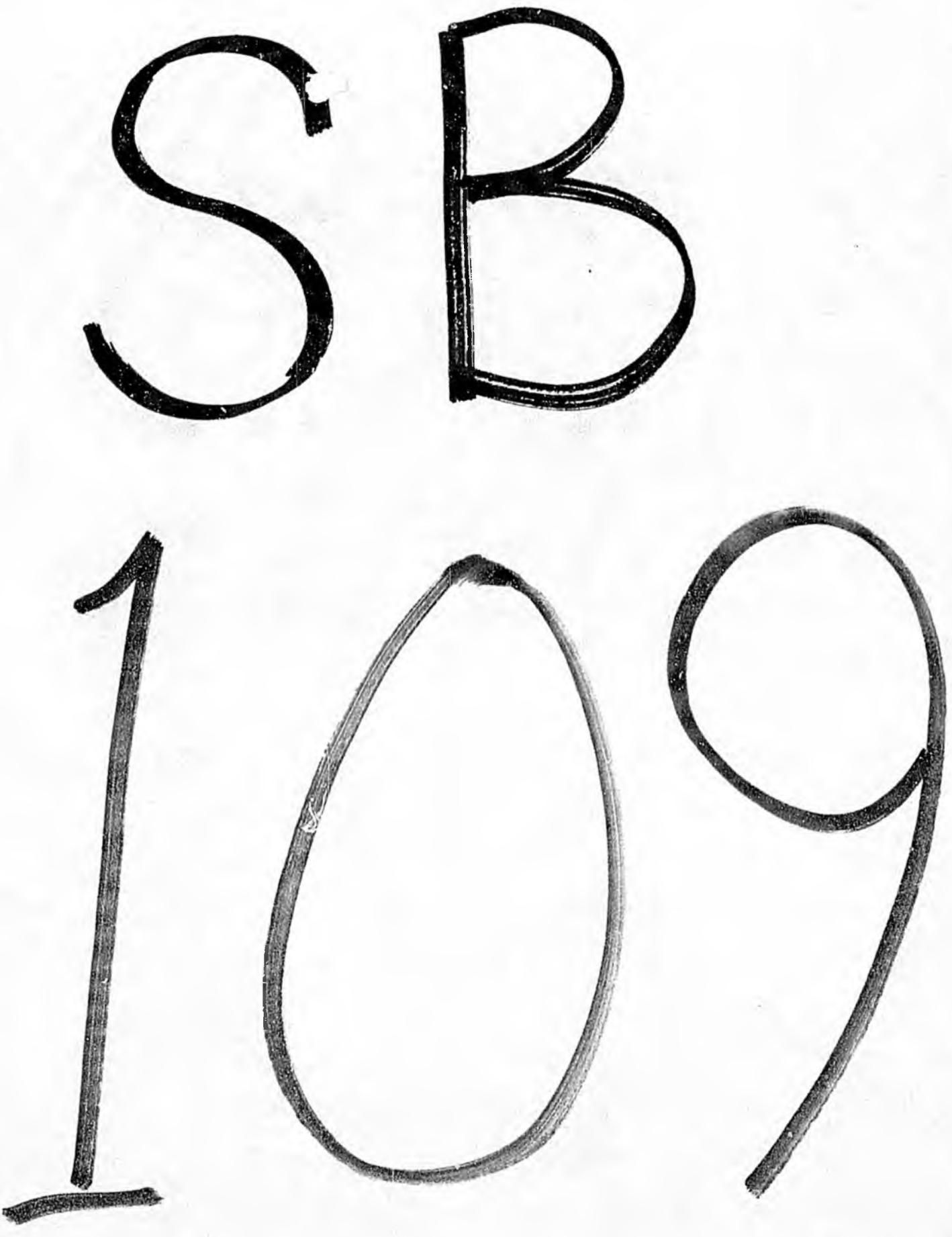
SB
109

COMMITTEE REPORT

HOUSE

(7)

FURTHER: FINANCE

4/24/85

Date: May 7, 1985

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had CSSB 109(HESS)

"An Act relating to provision of chiropractic services under the medicaid program."

under consideration and recommends:

[V] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

CHAIRMAN

Revisor's notes. — This section introduces a requirement which does not exist in this chapter, viz., filing a certificate with the board. It is the board's duty to keep a registry.

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Collateral references. — Practicing medicine, surgery, dentistry, optometry, podiatry, or other healing arts without license as a separate or continuing offense. 99 ALR2d 654.

Sec. 08.20.210. Fraudulent certificates. Any person who obtains or attempts to obtain a chiropractic certificate by dishonest or fraudulent means, or who forges, counterfeits, or fraudulently alters any such certificate is punishable by a fine of not more than $500, or by imprisonment for not more than six months, or by both. (§ 4 ch 53 SLA 1955)

Article 4. General Provisions.

Section
220. Chiropractic defined

Sec. 08.20.220. Chiropractic defined. Chiropractic is the science of locating and correcting interference with nerve energy transmission and expression within the human body, and the employment and practice of drugless therapeutics, including physiotherapy, hydrotherapy, mechanotherapy, phytotherapy, electrotherapy, chromotherapy, thermotherapy, thalmotherapy, correcting and orthopedic gymnastics, and dietetics which includes the use of foods and those biochemical tissue building products and cell salts found within the normal human body, without the use of drugs or surgery. (§ 35-3-22 ACLA 1949)

Opinions of Attorney General. — It is illegal and criminal for a chiropractor, without additional qualifications, to prescribe drugs or medicine to sick or injured persons. 1961 Op. Att'y Gen., No. 23.

Money cannot be expended from the fishermen's fund for the payment of charges for medicines prescribed by chiropractors. 1961 Op. Att'y Gen., No. 23.

Collateral references. — Chiropractors as within term "physician" in rule as to privileged communications. 68 ALR 177.

Kind or character of treatment which may be given by one licensed as chiropractic. 86 ALR 630.

Chapter 24. Collection Agencies.

Article
1. Collection Agency Board (§§ 08.24.011 — 08.24.031)
2. Powers and Duties of Department of Commerce and Economic Development (§ 1 — 08.24.071)
3. Licensing (§§ 08.24.090 — 08.24.380)

Revisor's notes. — The Collection Agency Board has been terminated under the provisions of AS 08.03 and AS 44.66. AS 08.03.010(b)(3) established a termination date of June 30, 1980.

Offered: 4/3/85
Referred: Finance

Original sponsors: Josephson, Abood and Fahrenkamp

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 109 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act related to provision of chiropractic services under the medicaid program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age clinic services, treatment of speech hearing and language disorders, physical therapy, occupational therapy, <u>chiropractic services,</u> prosthetic devices and medical supplies, long-term care noninstitutional services, and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 2. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the

following order:

(1) aged, blind, or disabled persons who

(A) do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act); and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title IV A, Social Security Act, Aid to Families with Dependent Children);

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the

standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(10) treatment of speech, hearing, or language disorders;

(11) physical or occupational therapy;

(12) care at an intermediate care facility for the mentally retarded;

(13) care at an inpatient psychiatric facility;

(14) community mental health clinic services;

(15) surgical care center services;

(16) nurse midwife services;

(17) medical supplies and equipment;

(18) long-term care noninstitutional services;

(19) chiropractic services.

* Sec. 3. AS 47.07.900 is amended by adding a new paragraph to read:

(7) "chiropractic services" includes only services that are provided by a chiropractor licensed under AS 08.20 that consist of treatment by means of manual manipulation of the spine and x-rays necessary for treatment.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
CSSB 109

Josephson,

"An act relating to provision of chiropractic services under the Medical Assistance program".

I. Background

CSSB 109 would modify the Medicaid program to add chiropractic services. Currently, approximately 29 states include chiropractic services in their Medicaid program. In addition, many major private insurance programs include chiropractic coverage. Generally, chiropractors and advocates of their services contend that chiropractic services are an alternative to other, potentially more costly medical treatments. However, States that have chiropractic services as part of their Medicaid programs have not reported reductions in the utilization of other health care services.

CSSB limits coverage to the two services covered under federal Medicaid rules i.e., manual manipulation of the spine and x-rays necessary for treatment. The added FY86 costs to include chiropractic services if limited to these two services is anticipated to be $174.0, ($87.0 in state funds).

II. Departmental Position:

Chiropractic services would be a good addition to the medical services currently offered under Medicaid, but the added cost associated with this new service is not in the Governor's budget and would have to be added by the Legislature.

Recommended By: Kimberly Busch for
Rod Betit, Director
Division of Medical Assistance

Date: 4/16/85

Approved By: John R. Pugh
John R. Pugh, Commissioner
Department of Health & Social Services

Date: 4-18-85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB109

Title: An Act relating to provision of chiropractic services under Med. Asst.

Sponsor: Josephson, Abood, Fahrenkamp

Requestor:

Date of Request: 2/6/85

FISCAL DETAIL

Agency Affected: Health & Social Services

Program Category Affected:

BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL	-0-	20.0	-0-	-0-	-0-	-0-
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS	-0-	154.0	160.0	166.4	173.0	180.0
800 MISCELLANEOUS						
TOTAL OPERATING	-0-	174.0	160.0	166.4	173.0	180.0
CAPITAL		-0-	-0-	-0-	-0-	-0-
REVENUE		-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUNDS		87.0	80.0	83.2	86.5	90.0
FEDERAL FUNDS		87.0	80.0	83.2	86.5	90.0
OTHER						
TOTAL		174.0	160.0	166.4	173.0	180.0

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: Attach a separate page if necessary

Please see attached analysis for method used to determine FY86 cost of $174.0. A 4% inflator was used to estimate cost for FY87 and each year thereafter.

Prepared By: Rod Betit, Director — Phone: 465-3355

Division: Medical Assistance — Date: 2/6/85

Approved by Commissioner: — Date: 2/14/85 cc

Agency: DEPT. OF HEALTH & SOCIAL SERVICES

Distribution (by Agency preparing fiscal note):

Legislative Finance

Legislative Sponsor

Requestor

ANCHORAGE CENTER FOR CHIROPRACTIC, INC.
KENNETH O. KETZ, D.C., AND ASSOCIATES
3126 SEWARD HIGHWAY
ANCHORAGE, ALASKA 99503
PHONE 274-7621

To date there are twenty-eight states which have chiropractic care covered in their medicaid programs, and one state pending.

They are as follows:

1. Arkansas
2. California
3. Kentucky
4. Idaho
5. Illinois
6. Indiana
7. Iowa
8. Kansas
9. Louisiana
10. Maine
11. Michigan
12. Minnesota
13. Nebraska
14. Nevada
15. New Hampshire
16. New Nersey
17. North Carolina
18. North Dakota
19. Ohio
20. Oregon
21. Pennsylvania
22. South Carolina
23. South Dakota
24. Texas
25. Utah
26. Washington
27. West Virginia
28. Wisconson

* 29. New York - Pending

More information will be forwarded to you as I receive and segregate it.

Sincerely.

Francis L. Corbin D.C.

F. L. (Butch) Corbin, D.C.

FLC/dh

CSSB 109
Fiscal Note Attachment
Cost Analysis for Chiropractic Services

Additional Contractual Costs

The Alaska Medical Payments System will require modification to pay chiropractors as a new service. The contractual costs include the following: provider manuals, training, a new claims form, tables included in the system for chiropractic services, computer programming, computer reports, the addition of collocation codes, the provision of notice to providers, provider relations, and a computer system test.

Additional Grants/Claims Costs

These figures were adjusted by an inflation factor of 4%. This is the average percent increase experienced during the past two years in chiropractic services. These costs are for only manual manipulation of the spine and the x-rays necessary for diagnosis. Again, these are the only chiropractic services for which federal reimbursement is available. The federal match for Medicaid is 50%.

(#Recipients X #Services X Cost/Service + #Recipients/mth X #X-Rays X Cost/X-Ray X 12 mths)
/Month /Month /Month /Month

[(50 X $30 X 2) + ($65 X 50 X 3)] 12 = $154.0 + 1 time Administrative Cost $20 = $174.0]

Assumption #1:

Alaska's ratio of recipients to eligibles is similar to the ratio of recipients to eligibles in Idaho.

Idaho averaged 75 chiropractic recipients and 30,000 eligibles per month. Therefore we estimate Alaska would average 50 chiropractic recipients out of 20,000 eligibles per month.

Assumption #2:

Services would be limited to 2 visits per month per recipient.

Assumption #3:

X-rays would be limited to three x-rays per month per recipient.

Assumption #4:

Manual manipulation of the spine costs $30. An x-ray costs $65.55.

According to the Health Care Financing Administration's publication "Medicaid Services State By State", attached, there are currently 27 states that include chiropractic services in their Medicaid Program. These states are:

Arkansas*	Iowa	Nevada*	North Dakota
California*	Kansas*	New Hampshire*	South Dakota
Connecticut	Louisiana*	New Jersey	Texas*
Idaho*	Maine*	North Carolina*	Vermont*
Illinois*	Michigan*	Ohio*	Washington*
Indiana	Minnesota*	Oregon*	West Virginia*
	Nebraska*	Pennsylvania	Wisconsin*

According to their individual Medicaid State Plans, at least 20 of the above states place limits on the number of chiropractic visits with one state limiting visits to emergency situations. (See attached excerpt from State Plans.) All of the above states place limits on the type of chiropractic services that can be reimbursed with many states only paying for manual manipulation of the spine and not x-rays provided by chiropractors. Some states that do not place limits on the number of chiropractic visits do require the state agency to prior authorize this service for each recipient.

Excerpts from Wisconsin's regulations are attached as an example of the regulatory language used to limit chiropractic services in that state.

* These are the states with limits on visits.

MEDICAID SERVICES STATE BY STATE

Basic Required Medicaid Services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning
- Physician services

Federal financial participation is also available to States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

* Report of services not received from these states.

FMAP[1]	● CN[2] ✦ Both CN and MN[3] BASIC REQUIRED MEDICAID SERVICES		Optional Services in State Medicaid Programs																	Services for Age 65 or Older in TB Institutions			Services for Age 65 or Older in Mental Inst								
			Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services
72	●	Alabama		●				●					●		●	●					●						●	●			●		
50	●	Alaska		●				●		●	●	●			●	●								●			●		●			●	
61		Arizona[4]																															
74	✦	Arkansas		✦	✦	✦		✦	✦				✦	✦	✦	✦					✦	●	●	✦	●	●	●	●	✦		●	✦	●
50	✦	California	✦	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	
50	●	Colorado	●	●				●	●				●			●								●	●	●	●	●	●		●	●	
50	✦	Connecticut	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦			✦	✦	✦		✦	✦	
50	●	Delaware	●	●		●	●	●					●		●	●	●	●						●		●	●	●	●		●	●	
50	✦	D.C.	✦	✦		✦		✦		✦			✦		✦	✦	✦		✦	✦	✦			✦			✦	✦	✦		✦	✦	✦
58	●	Florida	●	●		●		●	●			●	●	●	●	●					●			●			●	●			●	●	
67	●	Georgia	●	●		●		●	●				●	●	●	●					●	●	●		●	●	●	●			●		
50	✦	Guam		✦				✦	✦			✦	✦			●																	
50	✦	Hawaii	✦	✦		✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦			✦	✦	✦		✦	✦	✦
67	●	Idaho	●	●	●			●		●			●							●				●			●	●			●	●	●
50	✦	Illinois	●	✦	●	●	✦	✦	✦	●	✦	●	✦	✦	✦	✦	✦		✦	✦				✦	✦	✦	✦	✦	●		✦	●	✦	
60	●	Indiana	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●	●	●			●			●	●	●	●	●	●		
55	●	Iowa	●	●	●	●		●	●	●	●	●	●	●	●	●				●				●			●	●	●			●		
51	✦	Kansas	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦					✦	✦	✦	✦	✦			✦	✦	✦
71	✦	Kentucky		✦		✦		✦	✦	✦	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦			✦	✦	✦	✦	✦	✦			✦	✦	
64	✦	Louisiana		✦	✦			✦					✦	✦	✦	✦		✦		✦	●			●	●	●	●	●	●			●		
71	✦	Maine	✦	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦		✦	✦	✦	●	✦	✦	✦	✦	✦	●	✦	
50	✦	Maryland	✦	✦				✦	✦	✦			✦	✦	✦	✦					✦			✦			✦	✦	✦			✦	✦	
50	✦	Massachusetts	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦			✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	
51	✦	Michigan	✦	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦							✦	✦	✦	✦	✦	✦			✦	✦	
53	✦	Minnesota	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦			✦	✦	
78	●	Mississippi		●				●	●				●			●					●			●			●	●			●	●	
[illegible]	●	Missouri	●	●				●	●	●	●	●	●	●	●	●	●	●	●	●	●			●			●	●	●			●		●
64	✦	Montana	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦	✦	✦	✦	✦	✦			✦	✦	
57	✦	Nebraska	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦								✦	✦	✦	✦	✦	✦			✦	✦	
50	●	Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●					●	●	●	●	●	●	●	●	●			●	●	●
69	✦	New Hampshire	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦			✦		●	●	●	✦	✦		✦	✦	✦
50	●	New Jersey	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●	●	●	●	●		●	●	●	●
69	●	New Mexico	●	●		●		●	●	●			●	●	●	●				●							●	●			●	●	
50	✦	New York	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦	✦	✦	✦	✦	✦			✦	✦	
70	✦	North Carolina	✦	✦	✦			✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦					✦	✦	✦	✦			✦		
81	✦	North Dakota	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦			✦	✦	✦	✦	✦	✦			✦	✦	
50	✦	N. Mariana Islands		✦				✦	✦	✦	✦	✦	✦	✦	✦	✦																	✦	
55	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●							●	●	●		●	●	●	
58	✦	Oklahoma	✦					✦	✦				✦		✦					✦							✦	✦			✦	✦		
57	●	Oregon	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●				●			●	●	●		●	●	●	●
56	✦	Pennsylvania	✦	✦	✦	✦		✦	●				●	●	●									✦	✦	✦	✦	✦				✦	✦	
60	✦	Puerto Rico						✦	✦	✦	✦	✦	✦				✦	✦	✦	✦													✦	
58	✦	Rhode Island	●	✦					✦				✦	✦	✦	✦											✦	✦				✦		
74	✦	South Carolina	✦					✦					✦		✦						✦			✦			✦	✦	✦			✦	✦	
68	●	South Dakota			●			●	●	●			●	●	●						●			●			●	●				●	●	●
71	✦	Tennessee						✦	✦				✦		✦	✦					✦	✦	✦	✦	✦	✦	✦	✦			✦	✦		
54	●	Texas	●	●	●	●							●		●	●				●	●						●	●			●	●	●	●
71	✦	Utah	✦	✦		✦		✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦				✦	✦	✦	✦	✦				✦	✦	✦
69	✦	Vermont	✦	✦	✦	✦		✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦	✦				✦			✦	✦				✦	✦	
50	✦	Virgin Islands						✦	✦	✦	✦	✦	✦	✦	✦	✦																		
57	✦	Virginia	✦					✦	✦	✦	✦	✦	✦		✦						✦			✦	✦	✦	✦	✦				✦	✦	
50	✦	Washington	✦	✦	●	✦	✦	✦		●		●	✦	✦	✦	✦	●		✦	●	✦	✦	✦	✦	✦	✦	✦	✦			✦	✦		
71	✦	West Virginia	✦	✦	✦	✦	✦	✦		✦		✦	✦	✦	✦	✦								✦	✦	✦	✦	✦		✦		✦	✦	
57	✦	Wisconsin		●	●	✦	✦	✦	●	✦	✦	✦	●	●	✦	●	✦	✦	✦	✦	✦	✦	✦	●	✦	✦	✦	✦	✦		●	✦	✦	
50	●	Wyoming		●				●		●			●		●					●							●				●			
●	19	●	16	19	12	11	4	18	16	13	7	11	19	13	16	19	4	2	3	10	8	2	2	14	9	13	22	21	11	1	8	20	15	8
✦	35	✦	24	28	15	21	13	34	27	25	20	24	33	22	30	25	18	16	19	21	13	5	6	26	16	16	28	26	22	5	10	27	26	16
	54	Total	40	48	27	32	17	40	42	38	27	35	52	35	46	44	22	18	22	31	21	7	8	40	25	29	50	47	33	6	18	47	41	24

[1] Federal Medicaid Assistance Percentage (FMAP). Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Percentages are rounded and effective as of October 1, 1983.
[2] Categorically Needy. People receiving federally supported financial assistance.
[3] Medically Needy. People who are eligible for medical but not for financial assistance.
[4] Arizona operates a medical assistance program under a Section 1115 Demonstration project.

Reference: The data shown were reported by individual states and compiled by the Office of Intergovernmental Affairs.
HCFA Pub. No. 02155-85

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5. Physician's Services

(1) Twelve visits a calendar year in a physician's office, patient's home, or nursing home.

(2) Inpatient hospital services for hospital covered days for each attending physician with a maximum of two visits per day for each attending physician.

(3) Twelve visits a calendar year for hospital outpatient visits.

(4) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(5) Desensitization injections limited to persons under 21 years of age through EPSDT Screen.

6. b. Optometrist's Services

Examination of eyes and provision of glasses and other diagnostic screening, preventive and rehabilitation services and treatment of conditions found for eligible persons with prior authorization from the Utilization Review Section.

c. Chiropractor's Services

(1) Services limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HEW under Title XVIII.

(2) Limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the state.

(3) Services limited to twelve visits per calendar year.

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State: California

OFFICIAL

78-12

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Item	Limitation - Applicable to CH & ICF
1 - Inpatient Hospital Services (51327)	Subject to PA and specified length of stay as approved.
2 - Outpatient Hospital Services (51331)	Subject to limitations and contracts established for the particular service being rendered -- same as for services rendered outside hospital OP department.
2.b - Rural Health Clinic Services (51331.5)	Subject to program limitations for the specific services rendered.
3 - Lab and X-Ray (51311)	Subject to Rx of licensed practitioner acting within scope of practice.
4.a - SNF (51335)	Subject to preadmission authorization and periodic reauthorization.
4.c - Family Planning	Subject to program limitations for the specific services rendered.
5 - Physician Services (51305)	Subject to prior authorization for more than eight psychiatric visits or eight allergy hyposensitization visits in a 120-day period. Services for cosmetic purpose not covered. Prior authorization required for sterilization services.
6.a - Podiatry (51310)	Subject to prior authorization for more than two occasions of outpatient service per month and all services provided in SNF and ICF.
6.b - ~~Optometry (51305)~~ Obsolete Dec. 31-77 A-131 See next page	~~Limited to a total of two occasions of service per month from among the services of practitioners listed in 6a through c, and 11a through c. Orthoptics and pleoptics not covered.~~
6.c - Chiropractic (51308)	Limited to manual manipulation of the spine. Limited to a total of two occasions of service per month, from among the services of practitioners listed in 6a through c, and 11a through c.
6.d - Other Practitioners (51309)	Limited to a total of two occasions of services per month from among the services of practitioners listed in 6a through c, except outpatient physical therapy which is subject to prior authorization of an approved treatment plan.

Calif. Tr. 9/21/78 Incorp. 9/20/78 Effective 7-1-78

3.1–A Connecticut

OFFICIAL 80-10

1. Inpatient Hospital Services

No limitation on services.

2. Outpatient Hospital Services

Prior authorization required for special services beyond clinic visit (i.e. psychological - occupational, speech, hearing and physical therapy services).

3. Other Laboratory and X-Ray Services

No limitation on services.

4. a. Skilled Nursing Facility Services etc.

Initial review to determine level of care made by a Medical consultant within 14 days of patient's admission to a facility. Periodic patient reviews are made thereafter by a team (physician, nurse and social worker) to determine continued need for skilled nursing services.

4. b. EPSDT

No limitations on screening.

4. c. Family Planning Services

No limitations on services.

5. Physicians' Services

Hemodialysis Service — Prior authorization is required initially for 3 months. All subsequent requests are required every 6 months.

6. Medical Care and any other type of Remedial Care

a. Podiatrists

In SNF and ICF prior authorization is required for all services beyond the first visit in a 90 day period except for certain services listed in policy.

b. Optometrists

Tonometry is included in the annual exam. Visual training, visual motor or perceptual evaluation require prior authorization.

c. Chiropractors

Prior authorization required for procedure not specified in Fee Schedule.

d. Other

Naturopaths

Prior authorization required for procedure not specified in Fee Schedule.

Psychologists

Prior authorization for therapy services.

ST. Conn. 3/21/80 6/23/80

Effective 3/21/80

82-17

STATE Idaho

Attachment 3.1A Program Description

5. Physician Services: Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. However, the following services are excluded: bio-feedback therapy; physician services for the diagnosis or treatment of obesity in cases where obesity is the sole or principal diagnosis, including the supply of oral or injectable medication; cosmetic surgery which is not medically necessary and is not authorized by prior approval of the Department; intestinal bypass surgery for the treatment of morbid obesity; gastric stapling procedures; acupuncture; and examinations for the purpose of routine checkups (other than those associated with the EPSDT program) or in connection with the attendance, participation, enrollment, or accomplishment of a program or for employment.

   Abortion Services: The Department will only fund abortions to save the life of the mother. In addition, two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

6. a. Podiatrist's services are limited to the treatment of acute foot conditions.

   b. Optometrist's services are limited to providing eye examinations.

   c. Chiropractic services are limited for payment to a total of two (2) office visits during any calendar month. The remedial treatment must involve the manipulation of the spine and to correct a subluxation condition demonstrated to exist by x-ray.

   d. Services under other practitioners include those services provided by nurse practitioners and physician assistants and as defined by state and federal law.

State Illinois

OFFICIAL - 77-25

6.c. CHIROPRACTORS' SERVICES

Covered services are limited to those provided by chiropractors who meet standards promulgated by the Secretary of the Department of Health, Education and Welfare, and consisting of treatment by means of manual manipulation of the spine.

Prior approval is required for continuous treatments involving more than six (6) visits or exceeding a period of twenty-one (21) days.

5. Physician Services (cont'd)

6. Prescriptions for any and all over-the-counter and non-legend pharmacy items except ostomy supplies, topical antibiotics, catheter supplies (trays, irrigation solutions, catheters), enemas, laxative suppositories, bulk-producing laxatives, stool softeners, antacids, milk of magnesia, aspirin and acetaminophen.
7. Hyperalimentation therapy in other than in-patient hospital care setting.

6a. Podiatrists' Services

Provided with limitations.

Prior review and authorization by the Department shall be required for podiatry services and materials except emergency, initial evaluative examinations, and services specifically ordered in writing by a physician for patients with a peripheral vascular disease, diabetes mellitus, peripheral neuropathy, diseased/deformed nails and/or painful keratosis, acute infections, and fractures of the bones of the foot.

6b. Optometrists' Services

Provided with limitations.

Prior review and authorization by the Department shall be required for optometric services except the initial examination.

6c. Chiropractors' Services

Provided with limitations.

Prior review and authorization by the Department shall be required for all chiropractic services.

LIMITATIONS ON SERVICE

6.c. CHIROPRACTORS' SERVICES

Coverage of chiropractic services is limited to that in effect in Part B of Medicare.

Kansas

78-13

3.1-A Limitation

#6c. Chiropractic Services

Therapy beyond the first period of 90 days shall have prior authorization for reimbursement. A progress report shall be submitted after the first 60 days, following date of the first visit, and every 60 days thereafter. This report shall contain the history of present illness, diagnosis, type or mode of treatment, program of patient under the treatment and prognosis. Office visits and manipulative treatments by a chiropractor in excess of three (3) per month plus home visits in excess of one per month shall not be covered unless medical necessity is documented. Only spinal manipulations for conditions that are neuromuscular skeletal shall be covered.

Kansas Tr. 10/25/78 Incorp. 12/21/78 Effective 10/1/78

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

CITATION

42 CFR 440.60 — Medical and Remedial Care and Services

Item 6a. (Cont.)

Excision neuroma foot (add 10% each additional nerve).

(4) Payment of Podiatry services for residents in institutions or nursing facilities are made only when documented as an order by the attending physician. The order must be on the patient's chart and must state the condition necessitating podiatry services. A copy of the attending physician's order must be attached to the claim form for payment.

(5) Payment will not be made for routine foot care and the following services:

Cutting and removal of corns, warts, and calluses.
Trimming of nails and other hygienic and preventive maintenance care.
Assistant surgery fees for podiatric procedures.

Item 6b. Optometrists' Services

Payment is made to optometrists for cataract glasses or contact lenses following cataract surgery.

Item 6c. Chiropractic Services

The Office of Family Security makes payments to chiropractors for their services under the following conditions:

(1) Payment will be made to chiropractors who are licensed by the state and who are certified by Licensing and Certification Section for participation in Medicare (Title XVIII).

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICE ARE DESCRIBED AS FOLLOWS:

CITATION

42 CFR 440.60 — Medical and Remedial Care and Services
Item 6c (Cont.)

(2) Payment will be made only for chiropractors treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray to exist which the chiropractor is legally authorized to perform by the State (CPT Code 9485). The restriction of payment for services to treatment by manual manipulation precludes payment for diagnostic X-rays taken by chiropractors.

(3) Payment will be made for up to six chiropractic visits per calendar year. There is no provision for any additional visits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State Maine

Attachment 3.1-A
Page 2 Effective 10-1-75

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

76-33

DATE OF FINAL APPROVAL

Item 6a. Podiatrists' Services

Limited to non-routine procedures only, viz., treatment of plantar warts, ingrown nails, ulcerations, bursitis, and infections of the foot, and minor surgical procedures under local anesthesia. Also, some routine procedures complicated by foot pathology (such as nail-clipping of severe diabetics with onychomycosis) are covered.

Item 6b. Optometrists' Services

Limited to first pair of eyeglasses following eye surgery and diagnostic examination. Individuals covered under EPSDT are eligible to receive other services subject to the following limitation: examination and eyeglasses may only be provided for more than minor refractive error.

Item 6c. Chiropractors' Services

Limited to treatment by means of manual manipulation of the spine. Covered visits cannot exceed 2 per week for one month for an acute condition or six visits for a chronic condition. Ongoing treatment requires justification every 12 months.

Item 6d. Other Practitioners' Services

Clinic psychologists

Limited to evaluation, individual or group psychotherapy, psychometric testing, emergency care, and crisis intervention. Limited to one hour of therapy per day and five sessions per week.

Psychological Examiners

Limited to psychometric testing.

St. Maine Tr. 5/5/76 Incorp. 7/8/76 Effective 10/1/75

STATE PLAN

6. MEDICAL CARE FURNISHED BY LICENSED PRACTITIONERS WITHIN SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (Same for categorically needy and medically needy clients)

No payment will be made for services of staff in residence or medical staff functioning in an administrative capacity for a hospital or nursing care facility, including practitioner-owners. In relation to outpatient services, practitioner fees for covered services are payable only when such payment does not duplicate payment to the facility.

a. Podiatrists' Services

Services provided within the scope of his profession, as defined by State law, by a licensed podiatrist are covered, whenever funished, when related to a diagnosed health condition calling for therapeutic management. Routine examinations are excluded, unless medically necessary for diagnosis or treatment of an illness or injury, or for the prevention of disability, or unless provided to individuals under age 21 as part of the EPSDT program. (See Item 4b of this attachment.)

b. Optometrists' Services

Covered services include:

1. Complete eye examination if medically necessary. Examinations which exceed a frequency of once every two years must be documented as medically necessary.

2. The following corrective lenses, all of which require prior authorization:

   a) single-vision or multi-focal eyeglasses;

   b) cataract lenses;

   c) contact lenses, evaluations and services;

   d) special lenses, as specified by the department.

3. Orthoptic and low vision evaluations, services and aids (which must be prior authorized).

Requirements relative to the provision of eyeglasses are described in Item 12d (page 5b) of this attachment.

c. Chiropractors' Services

Services provided within the scope of his profession, as defined by State law, by a licensed chiropractor are covered only as follows:

1. With respect to treatment of the spine by means of manual manipulation; and
2. Upon a primary diagnosis of subluxation.

Chiropractic services are limited to up to ten (10) visits during the initial month of treatment and up to a maximum of six (6) visits in each succeeding month until a 12 month maximum of 24 visits has been reached. If more than 24 visits per year are needed, medical necessity must be thoroughly documented.

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6.b. Optometrists' Services

- Services provided for cosmetic reasons are not covered, nor are technical support services related to them.
- The following services must be prior authorized:
  - Contact lenses.
  - Custom-fit prosthetic eye.
  - Amblyopia therapy.
  - Vision therapy - supplemental evaluation and request.

6.c. Chiropractors' Services

- Provision is limited to manual manipulation of the spine.
  (X-rays required to document a diagnosis of subluxation are covered under 6.d.)
- Provision is limited to six treatments per month and 24 per calendar year. Additional treatments are allowed only with prior authorization.

6.d. Other Practitioners' Services

- Services of licensed midwives are provided.
- Chiropractic x-rays required to document a diagnosis of subluxation.
- Services provided by psychiatrists and psychologists are limited to those described below. The limitations may be exceeded only with prior authorization.

Description of Service	Limitations
Psychiatric diagnostic interview examination including history, mental status, or disposition	Once per month — not more than three (3) times per calendar year
Psychological testing, psychometric and/or projective tests including interpretation, psychiatric evaluation of hospital records, psychiatric or psychological reports, and other accumulated data for diagnostic purposes without other informants or patient interview	Once per month — not more than three (3) times calendar year

three weeks in licensed rehabilitation beds, (e) bassinet service for newborns from birth until their mothers are discharged, and (f) licensed chemical dependency units. Length of stay is limited as specified for diagnoses and operations in the *Professional Activities Study* (PAS) for hospitals in the North Central Region published by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, unless utilization review discloses need for additional stay. If the patient needs but cannot obtain lower level care, the program may approve three additional hospital days at the rate payable for the level of care needed. Weekends and holidays are not counted in those three days. Alcohol and chemical detoxification is covered up to five days unless the program approves additional days. Prior authorization is required for cosmetic surgery, hospitalization for dental procedures, procedures of questionable value, and certain other care as specified by the program. Rural hospitals with 49 or fewer beds may qualify as swing-bed hospitals if so approved by the state health planning agency.

2. Outpatient hospital services. These include when medically necessary: (a) surgical procedures including those in "surgicenters"—hospital-based facilities not located on the hospital's premises, (b) therapeutic and/or diagnostic services including radiology, pathology, and cardiac testing; (c) emergency room care when an emergency exists, (d) dental surgery by prior authorization; (e) hemodialysis, (f) drugs and supplies only if used in the emergency or outpatient facility, (g) psychotherapy not exceeding $500 per patient per year except by prior authorization, (h) partial hospitalization for psychiatric care, and (i) outpatient psychiatric services in hospitals certified to provide them.

2a. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

3. Other laboratory and X-ray services. Also included are portable X-ray services.

4. Skilled nursing facility services. These are provided for: (a) patients of all ages excluding those in institutions for tuberculosis or mental diseases; and (b) patients 65 or older in institutions for mental diseases. Payment is made for reserving beds during temporary absence of up to 15 days per hospitalization for acute conditions, and for therapeutic leave of absence up to 18 days (36 days for an ICF/MR patient) per patient per year. Additional therapeutic leave days require prior authorization. Bedholding days are prorated when a patient is in a facility for less than a year. Payment is not made for reserved beds when the patient is classified as needing "chronic or convalescent" care—this is more intensive than ordinary SNF or ICF care.

4a. Intermediate care facility services. These are provided for: (a) all patients excluding those in institutions for tuberculosis or mental diseases but including patients in institutions for the mentally retarded or related conditions; and (b) patients 65 or older in institutions for mental diseases. See 4, above, regarding reserved beds.

5. Physicians' services. These are covered within the practice of medicine and osteopathy defined by state law. Second surgical opinions are covered. Program approval is required for visits to a hospitalized patient exceeding one per day by a primary physician or one per week by a consulting physician. Excluded are: (a) experimental or unproven procedures listed by the program, (b) sex change procedures, (c) reversal of tubal ligation or vasectomy; (d) cosmetic procedures except by prior authorization when scars are disfiguring or limit motion, and (e) outpatient psychotherapy exceeding $500 per patient per year except by prior authorization.

6. Podiatrists' services. These include: (a) an initial office visit; (b) routine palliative care once every 30 days for an ambulatory patient or once every 90 days for a nonambulatory patient, including cutting or removing corns or calluses, debridement, and other hygienic or preventive maintenance as specified by the program; (c) surgery which includes 14 days of postoperative care unless more payment is needed for casts or orthotic devices, (d) orthotic appliances or devices, subject to prior authorization, including follow-up care related to these items, and (e) orthopedic shoes, corrections, braces, or any other necessary supplies or items, subject to prior authorization for each line item exceeding $50.

6a. Optometrists' services. These are limited to: (a) one routine eye examination, change of lenses, and frame every 24 months, except that children referred through EPSDT can receive a routine eye examination and lenses once every 12 months, (b) additional "limited" examinations in emergencies or when the patient has an eye disease or injury, (c) certain supplemental procedures, (d) replacement of stolen glasses if supported by a police report, (e) replacement of lost glasses subject to review by the program; and (f) contact lenses only when pathology precludes useful vision with regular glasses. Prior authorization is required except for: (a) routine examinations and lenses in EPSDT, (b) emergency examinations, (c) follow-up evaluations for identified pathologies; and (d) certain minor repairs of glasses. Sun glasses and photochromatic lenses are not covered.

6b. Chiropractors' services. These include: (a) one set of diagnostic X-rays per recipient per year; and (b) no more than one treatment per recipient per day, limited to manual manipulation of the spine as

79-9 OFFICIAL

State Nevada

Attachment 5.A
Page 2a

5. Physicians' services for outpatients are limited to two office visits per person per month for treatment of illness, two therapeutic injections per month, and emergency treatment. Services to hospital inpatients and family planning services are not limited.

6.a. Podiatrists' services require prior authorization by the Medical Care Section on a SAMI-3 for other than emergency care.

b. Optometrists' services require prior authorization by the Medical Care Section on a SAMI-12. Refractions are limited to one in 36 months. For those individuals referred for diagnosis from an Early Screening examination, refractions are not so limited.

c. Chiropractors' services are limited to emergency care only.

d. Other practitioners' services: Certified Registered Nurse Practitioners' services are limited to the same extent as are physicians' services (no. 5 above).

Nevada Tr. 3/21/79 Incorp. 4/9/79 [illegible] 1/1/79

New Hampshire

6b. Optometrists' Services

Payment for refraction is limited to one (1) every two (2) years, per recipient whether the provider is an optometrist or ophthalmologist.

6c. Chiropractors' Services

Manual manipulation of the spine is the only service for which payment will be made. These services are limited to four (4) per recipient per fiscal year.

6d. Other Practitioners' Services

Clinical Psychologist

Treatment provided by a certified clinical psychologist, who is not on the staff of a community mental health center, is covered up to twelve (12) services per fiscal year per recipient.

Community Mental Health Center

Treatment at Community Mental Health Centers is covered up to $500 per fiscal year per recipient, except for partial hospitalization and long-term treatment program services which may be exempt from the limit.

ST. N.H. SA Approved 3-19-82

RO Approved 4-23-82 Effective 1-1-82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

5. Prior authorization by local office required for elective cosmetic surgery. Prior authorization by State office for psychiatric services by a private practitioner, exceeding a payment of $300 in any 12 month period, is required.

After an initial visit, prior authorization will be required for psychiatric services rendered to Medicaid recipients in long-term care facilities and sheltered boarding homes (residential health care facility).

Physicians will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. Second opinions are not mandatory for Medicare/Medicaid eligible recipients.

6(a) Provided with exception of routine foot care, subluxations of the foot, treatment of flat foot conditions, and injections or drugs dispensed by a podiatrist to his own patients. Prior authorization required for molded shoes, arch supports, laboratory services rendered by a podiatrist for his own patients, and debridement of hypertrophic toenails, if done more than once every two months.

6(b) Prior authorization by State office required for optometric examinations in excess of one a year for persons under age 19 or over age 60, or one every two years for persons over age 19 or under age 60; for purchase of optical appliances, for repairs to optical appliances costing over $5; for visual training, and for other optometric treatment.

6(c) Provided but limited to manual manipulation of the spine. Chiropractors practicing in states other than New Jersey are not eligible for reimbursement.

6(d) Psychological services are provided. Prior authorization by State office for services by a private practitioner exceeding a payment of $300 in any 12 month period is required. Psychologists practicing in states other than New Jersey are not eligible for reimbursement.

After an initial visit, prior authorization will be required for psychological services rendered to Medicaid recipients in long-term care facilities and sheltered boarding homes (residential health care facility).

ST. N.J. Approved 9-4-81

RO Approved 3-11-82 Effective 4-1-82

6.c Chiropractors' Services

(1) Chiropractic services are limited to manual manipulation of the spine to correct subluxation which has resulted in a neuromusculoskeletal condition for which manipulation is appropriate. Conditions treated must be demonstrated to exist by x-ray taken within six months.

(2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additinal visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. EPSDT screens are excluded.

7. Home Health

Home health services are provided by certified Home Health Agencies under a plan of care authorized by the patient's physician. Covered home health services include nursing services, services of home health aides, speech therapy, physical therapy, occupational therapy, medical supplies, equipment, and appliances. A medical information form which details the services provided must be submitted with the claim form.

a. Intermittent or Part Time Nursing Services Furnished by a Home Health Agency.

(1) Care which is furnished only to assist the patient in meeting personal care needs is not covered.

(2) Intermittent or part-time nursing service by a registered nurse when no home health agency exists in the area is limited to a registered nurse employed by or under contractual arrangement with a local health department.

b. Home Health Aide Giving Personal Care Services According to a Plan of Treatment.

Categorically Needy Persons and Medically Needy Persons

1. Inpatient hospital services. For (a) all patients excluding those in institutions for tuberculosis or mental diseases, and (b) patients 65 or older in institutions for mental diseases.

2. Outpatient hospital services. Emergency room care is covered only in a medical or surgical emergency or when other medical necessity is documented by special report, except that emergency room care can also include certain screening/examination services.

3. Other laboratory and X-ray services.

4. Skilled nursing facility services. For patients of all ages excluding those in institutions for tuberculosis or mental diseases. Payment is made for reserved beds in nursing homes for recipients who are temporarily absent: (a) for 15 days maximum during a period of inpatient hospitalization, and (b) for 18 days per year maximum for leaves of absence, except additional days may be paid for if recommended by the attending physician and included in the patient's plan of care.

4a. Intermediate care facility services. For all patients excluding those in institutions for tuberculosis or mental diseases but including patients in institutions for the mentally retarded or related conditions. See 4, above, regarding reserved beds.

5. Physicians' services. These are services provided within the scope of practice of the physician's profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

6. Podiatrists' services.

6a. Optometrists' services. Coverage includes (a) examination by a physician skilled in eye diseases or by an optometrist, and (b) eyeglasses (lenses, frames when necessary, and other aids to vision) that are prescribed by the physician or optometrist when the examination discloses visual impairment. Eyeglasses are limited to one pair per year, except in cases of refractive error, loss or breakage. A recipient is subject to a $3.00 copayment for glasses that are replaced because of loss or breakage, except that the copayment does not apply to children under EPSDT.

★ 6b. Chiropractors' services. Reimbursement limited to $12 per visit. X-rays not covered.

7. Home health services. Includes: (a) intermittent or part-time nursing service provided by a home health agency or by a registered professional or licensed practical nurse when no home health agency exists in the area, (b) home health aide services provided by a home health agency, (c) medical supplies, equipment, and appliances suitable for use in the home, and (d) physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility. For individuals of all ages.

8. Early and periodic screening and diagnosis of individuals under 21 and treatment of conditions found.

9. Family planning services and supplies. For individuals of childbearing age.

10. Private duty nursing services.

11. Clinic services.

12. Dental services. Orthodontia requires prior authorization and is limited to correction of functional disorders, cosmetic corrections are not covered. Dentures are covered.

13. Physical therapy and related services. Includes: physicial therapy; occupational therapy, and services for individuals with speech, hearing and language disorders (provided by or under supervision of a speech pathologist or audiologist).

14. Prescribed drugs. Prescribed diet remedies (as defined by the state Medicaid agency) and alcoholic beverages (spirits fermenti) are not covered.

15. Dentures. See 12, above.

16. Prosthetic devices.

17. Eyeglasses. See 6a, above.

18. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere under the program.

19. Inpatient psychiatric facility services for individuals under 21 or under 22 if confined beyond 21st birthday.

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State of Ohio

c. Chiropractor Services -- D.C.

Limited to four visits per month for patients in independent living arrangements for:

TREATMENTS

22500 MANIPULATION OF SPINE, ANY REGION, DURING OFFICE VISIT

27270 MANIPULATION SACROILIAC JOINT (WITHOUT ANESTHESIA), INCLUDING OFFICE VISIT

This service is limited to manual manipulation only (effective December 27, 1974, for Medicare and Medicaid). This precludes any payment for diagnostic X-ray taken by the chiropractor.

d. Other Practitioner Services

Mechanotherapist Services -- D.M. or M.T.

Limited to four visits per month per provider for patients in independent living arrangements for services in the CPT Code, 3rd Edition, for which the practitioner is currently licensed.

The following services are not covered by the program:

Lab and X-ray services since such services are not in the scope of practice of a mechanotherapist.

Activities of daily living and diversional activities.

Office visit including tests or measurements for activities of daily living "check-out".

Licensed Psychologist Services

Covered services are those professional procedures listed in the State of Ohio Medicaid Handbook.

The following services are not covered:

- Services of psychologists provided in mental institutions and mental retardation institutions operated by the State Department of Mental Health and Mental Retardation.
- Services of school psychologists provided in facilities regulated by the State Board of Education.

5. Physicians' Services

Payment for physician's services is subject to published rules and instructions, and prior authorization of selected elective and rehabilitative procedures. Other selected procedures are not covered based on unproven efficacy and/or non-coverage by Medicare and other major third party payors, and after concurrence by appropriate provider representation. The AFS Physician Services Guide sets forth the fee schedule, rules and instructions. Elective, rehabilitative and other procedures not listed must be submitted for approval of payment by the Division's Health and Social Services Section. Applies to categorically needy only.

Non-emergency services provided by out-of-state physicians, other than in contiguous areas, must be prior authorized. Foster children who are Oregon residents living anywhere in the United States or Canada are exempt from this limitation.

6.a. Podiatrist Services

Podiatrist services are provided only in emergency situations when foot problems are directly related to acute disease or infection, acute injury and/or to relieve severe pain. Claims are reviewed prior to payment by the podiatry consultant or competent administrative staff based on criteria developed by the consultant. Applies to categorically needy only.

6.b. Optometrists' Services

Optometrist services are provided subject to rules and procedures set forth in the AFS Visual Services and Ophthalmic Materials Guides. Prior authorization for payment must be submitted to the AFS branch office for decision by the AFS branch office, local medical consultant or the Health and Social Services Section, as appropriate. Applies to categorically needy only.

6.c. Chiropractors' Services

Chiropractic services are provided with a limitation of no more than four visits in a month. All requests for payment are reviewed by a Chiropractic Consultant.

6.d. Other Practitioners' Services

Billings from Naturopaths are reviewed by a Naturopathic Consultant for appropriateness of billing and payment.

DESCRIPTION OF LIMITATIONS

SERVICE	LIMITATIONS
6. (CONTINUED) c. Chiropractors' Services Effective 9/1/80	Categorically Needy - Limited, only services that: (1) are provided by a chiropractor who is licensed by the State and meets the standards under 42 CFR 405.232(b); and (2) consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by Pennsylvania to perform. NOTE: Payment is not made for x-rays performed by a chiropractor. Medically Needy - Same as above.

South Dakota

SUPPLEMENT TO ATTACHMENT 3.1-A

1. Inpatient Hospital Services

Inpatient hospital services provided by a general acute care hospital are limited to: (1) 60 days of inpatient care during a benefit period as defined by Title XVIII of the Social Security Act; and (2) the first 3 pints of blood provided during each benefit period. Crippled Children's Hospital services are not subject to limitations.

4b. Early and Periodic Screening, Diagnosis and Treatment

The services covered under the EPSDT program which may be available for eligible individuals, shall include the procedures designed to ascertain the physical and mental defects, and the treatment of the conditions discovered, limited by the services provided under the medical assistance program; the provision of eye glasses, hearing aids, and other kinds of accepted treatment for visual and hearing defects; and dental care necessary to relieve pain and infection, restoration of teeth, and maintenance of dental health.

4c. Family Planning Services

Voluntary abortions are excluded from family planning services.

5. Physician Services

Physician services are limited to those services which are medically necessary and required by the patient. Routine physical examinations are not payable except when authorized by the Department. Payment for abortion is allowed only when the life of the mother is threatened and this fact has been properly documented by the attending physician.

6b. Optometrist's Services

Optometrist's services payable are limited to services under the Early and Periodic Screening, Diagnosis and Treatment Program.

6c. Chiropractic Services

Chiropractic services payable are limited to manual manipulation of the spine to correct subluxation which is demonstrated by X-ray to exist.

7. Home Health Services

a, b, and d. Services are limited to 100 visits per calendar year when preceded by hospitalization and 100 visits per calendar year without prior hospitalization. All services must be ordered by a physician.

c. Supplies and equipment are limited to the scope of benefits approved by Medicare.

10. Dental Services

Except for services provided under EPSDT for eligible children under 21 years of age, dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, full mouth extractions, and full dentures.

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Texas

Attachment to Attachment 3.1A

15. Paragraph 15 as submitted by Amendment Number 10, transmittal number 75-41, is hereby deleted.

16. Chiropractic Services. Coverage of chiropractic services is limited to services which consist of necessary treatment or correction by means of manual manipulation of the spine, by use of hands only, to correct a subluxation demonstrated by x-ray to exist. The x-ray must be done prior to such treatment. The chiropractor must be licensed to practice in Texas and must meet the uniform minimum standards promulgated by the Secretary of the Department of Health, Education and Welfare under Title XVIII of the Social Security Act.

Coverage for such treatment is limited to no more than 24 visits per recipient per 12 consecutive month period. A 12 consecutive month period begins with the first month in which services are provided.

Documenting x-rays will be kept on file and are subject to utilization review and audit procedures. Coverage of chiropractic services will be determined by the Single State Agency or its designated agent in accordance with the regulations, rules and procedures governing chiropractic services under Part B of Title XVIII of the Social Security Act. Coverage does not extend to the diagnostic, therapeutic services or adjunctive therapies furnished by a chiropractor or by others under his or her orders or direction. This exclusion applies to the x-ray taken for the purpose of determining the existence of a subluxation of the spine. Additionally, braces or supports, even though ordered by an M.D. or D.O. and supplied by a chiropractor, are not reimbursable items.

St. TEXAS Tr. 9/15/77 Incorp. 10/3/77 Effective 9/1/77

outpatient hospital, home health, or mental health clinic services; or (b) an exception is preauthorized for compelling reasons. Physician visits are limited as follows: hospital visits—one per day; SNF visits—one per week; ICF visits—one per month; office visits—up to five per month; home visits—up to five per month. Additional visits are covered if there is evidence of medical necessity. Payment for concurrent care is limited to one physician unless the care is part of a coordinated treatment plan. Not covered are: (a) new and experimental procedures, including acupuncture and certain organ transplants; (b) cosmetic surgery except for prompt repair of accidental injury or to improve functioning of a malformed body part; (c) hysterectomies solely for sterilization; (d) procedures of questionable value, and (e) redundant procedures.

6. Podiatrists' services. Covered podiatry services by a podiatrist, chiropodist, or other physician are limited to non-routine foot care such as surgical removal of ingrown toenails, treatment of foot lesions resulting from infection or diabetic ulcers, and similar Medicare-covered treatment according to policy applicable to all physicans' services. Excluded are treatment of flat foot conditions and supportive devices used in such treatment, treatment of subluxations of the foot except for surgery, cutting or removal of corns or calluses, trimming of nails, and preventive or hygenic care of the feet. A patient's inability to perform routine foot care does not cause such care to be covered.

6a. Optometrists' services. Provided are: (a) an eye examination to measure vision once every two years, (b) an interim eye examination, such as for glaucoma, every two years; (c) one pair of eyeglasses every two years—a second pair requires prior authorization; (d) repairs to glasses; (e) contact lenses, with prior approval; and (f) photosensitive materials added to lenses, with prior approval.

6b. Chiropractors' services. Coverage is limited to manipulation to correct a subluxation of the spine. An X-ray is required, but is not covered for payment. Only 10 treatments per recipient per calendar year are covered unless more are medically justified by the chiropractor. Prior authorization is required for services provided to a recipient under age 12.

7. Home health services. Included for individuals of all ages are: (a) intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area; (b) home health aide services provided by a home health agency; (c) medical supplies, equipment, and appliances suitable for use in the home; and (d) physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility—these are routinely covered for four months on physician's certification, and the period of treatment may be extended with prior authorization.

8. Early and periodic screening and diagnosis of individuals under 21 and treatment of conditions found.

9. Family planning services and supplies. These are provided for individuals of childbearing age. Coverage includes services of participating hospitals, physicians, pharmacies, and medical oriented services of Planned Parenthood of Vermont.

10. Clinic services. Covered are physicians' services billed by the clinic on the doctor's behalf and services and medical supplies incident to physicians' services. Indian Health Service facilities may qualify as providers on the same basis as other clinics, although a license is not necessary. Mental health clinic services are provided for outpatients in state-qualified mental health clinics that are not part of a hospital. Services must be provided according to a physician's plan of treatment for the patient. Mental health center services include diagnosis and evaluation and day treatment.

11. Dental services. Coverage for individuals age 21 and older is limited to: (a) excision of cyst or tumor of jawbone; (b) reduction of fracture of jaw or facial bone; or (c) extraction of teeth to prepare jaw for radiation. Services covered for children under 21 by the EPSDT program include: (a) complete examination and diagnosis including radiographs when indicated; (b) elimination of pain and infection, (c) treatment of injuries; (d) elimination of diseases of bone and soft tissue; (e) treatment of anomalies; (f) restoration of decayed or fragmented teeth; (g) treatment of malocclusion with priority for interceptive treatment, disfiguring and handicapping malocclusion; (h) periodic recall for prophylaxis and treatment services; and (i) replacement of missing teeth. Payment is not made for topical fluoride treatment. Prior authorization is required for EPSDT dental services for any plan of treatment in which it is estimated that total costs will exceed $20.

12. Physical therapy and related services. Included are: (a) physical therapy; (b) occupational therapy; and (c) services for individuals with speech, hearing, and language disorders if such services are provided by or under supervision of a speech pathologist or audiologist. Rehabilitative therapy services are covered under inpatient hospital services and are also covered as outpatient hospital services if they are part of a written treatment plan. Outpatient services are routinely covered for four months on physician's certification, and the period of treatment may be extended with prior authorization.

WASHINGTON

Categorically Needy Persons:	*Medically Needy Persons:*
6a. Optometrists' services. These are limited to a refraction and glasses once every 12 months except that this limit does not apply to children under EPSDT. Sunglasses, photochromic lenses, two pairs of glasses in lieu of bifocals or trifocals, contact lenses, orthoptics therapy, and glasses for cosmetic purposes are not covered. Examinations for providing certain lenses and frames require prior authorization. Group screening is not permitted.	6a. Same
6b. Chiropractors' services. These are limited to 20 visits per year (plus one visit for a new patient) to adjust subluxation of the spine by hand, and to X-rays limited to specified spinal areas. Out-of-state treatments cannot exceed three.	6b. Not provided.
6c. Psychologists' services. Psychological evaluations by a psychologist are covered when requested by a physician as part of an ongoing treatment plan and the request is approved by the program. Treatment by a psychologist is not covered.	6c. Same.
6d. Respiratory therapists' services. Services of respiratory therapists and technicians are covered in the patient's home or in a nursing home if program approval is obtained.	6d. Same.
6e. Certified registered nurse practitioners' services. Services of nurse practitioners are covered through agreements with nurse practitioner clinics on an individual basis.	6e. Same.
7. Home health services. Included for individuals of all ages are: (a) intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area, (b) home health aide services provided by a home health agency, (c) medical supplies, equipment, and appliances suitable for use in the home—there is no limit on medical supplies or on external braces for the neck, trunk, or extremities, but prior authorization is required to purchase equipment and appliances or to rent durable equipment, and (d) physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility—prior authorization is required when these are provided by a medical rehabilitation facility. Approval is required when home health service duration or monthly payment will exceed the program's limits.	7. Same, except that services in (d) are not covered when provided by a medical rehabilitation facility.
8. Early and periodic screening and diagnosis of individuals under 21 and treatment of conditions found.	8. Not provided.
9. Family planning services and supplies. These are provided for individuals of childbearing age, limited to physician, clinic, and hospital services, and supplies and drugs.	9. Limited to physicians' services and supplies.
10. Private-duty nursing services. These may be provided by a registered or licensed practical nurse if prior authorization is obtained.	10. Not provided.
11. Clinic services.	11. Same.
12. Dental services. Coverage of dental services is limited to children under EPSDT. It includes (a) initial and periodic oral examinations; (b) treatment necessary for relief of pain and infection, restoration of teeth, and maintenance of dental health, and (c) orthodontic treatment defined as use of any applicance, intra-oral or extra-oral, removable or fixed, or any surgical procedure designed to move teeth. Prior authorization is required for orthodontic treatment. Dentures are covered, limited to fabrication and fitting and subject to prior authorization.	12. Dental services—not provided. Dentures—covered the same as for the categorically needy.
13. Physical therapy and related services. Included are: (a) physical therapy when authorized to avoid need for hospitalization or nursing home care, assist recipient in becoming employable, or solve a medical need in unusual circumstances; and (b) speech therapy by prior authorization when provided by a speech pathologist.	13. Not provided.
14. Prescribed drugs. Coverage is limited to items in the agency's formulary except by prior authorization or in an emergency. Drugs for	14. Same.

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State West Virginia

3.1 Amount, Duration, and Scope of Assistance

ATTACHMENT 3.1-A and 3.1-B

Amount, duration, and scope of medical and remedial care and services provided.

1. Inpatient Hospital Services - Limited to 20 days in a fiscal year, July 1 through June 30.

2. a. Coverage for emergency room services limited to conditions related to accident, injury, or trauma.

4. a. Skilled Nursing Facility Services

Pre-certification required on each admission prior to authorization of benefits. Re-certification required for continued stay after initial certification.

6. b. Optometrists' Services

Routine provision of eyeglasses no more often than once per year for those individuals who are eligible for EPSDT services. Prior authorization required for appliances and visual training.

c. Chiropractors' Services

Treatment limited to manual manipulation of the spine; visits limited to six per fiscal year.

d. Other Practitioners' Services

Psychologists - Prior authorization required for therapy.

7. c. Medical Supplies, Equipment, Etc.

Special procedures must be preauthorized by the State agency.

8. Private Duty Nursing Services

Prior authorization required.

HCFA Approved 10-6-82 Effective 7-1-82

State Wisconsin

DESCRIPTION OF LIMITATIONS

All limitations described in this page and the next page are equally applicable to categorically needy and medically needy, unless otherwise noted.

1. Inpatient Hospital Services. For services requiring prior authorization see section HSS 107.08 of the Wisconsin Administrative Code.

Effective 11-1-81

2.a. Outpatient Hospital Services. Services to medically needy are restricted to federally mandated benefits. Prior authorization restrictions apply to hospitals when they provide the applicable service. Day treatment services require prior authorization after exceeding 120 hours (outpatient) 40 hours (nursing home) or 20 hours (inpatient), except that such services are not available to the medically needy. For a full description of limitations on the service, see section HSS 107.13 of the Wisconsin Administrative Code.

2.b. Rural Health Clinic Services. All Wisconsin Medicaid services requiring prior authorization are applicable to rural health clinics.

Disapproved per letter from C. Davis to Ken Kentmeister dated 12/30/81

4.a. Skilled Nursing Facility Services. Concurrent authorization of care and amount of payment based on plan of care and independent medical review. ~~Medically needy residents remain eligible to receive any optional services necessary to support their nursing home care. Reimbursement for levels ICF 3 & 4 is available only if the person entered the facility before October 1, 1981 and has continuously resided in a facility since that date, or, if the person has a primary diagnosis in the areas of developmentally disabilities or chronic mental illness.~~

Effective 10-1-81

4.c. Family Planning Services. Sterilization procedures require prior authorization and the informed consent requirements under federal regulations.

5. Physicians' Services. Transsexual surgery and artificial insemination are not covered services. For services requiring prior authorization see section HSS 107.06 of the Wisconsin Administrative Code. Certain elective surgical procedures require a second surgical opinion in order for Medicaid reimbursement to be available. If a second opinion is obtained, reimbursement for the surgery will be made regardless of whether the second opinion confirms or disconfirms the first opinion. Procedures requiring a second opinion are: cataract extraction; cholecystectomy; certain D & C procedures; hemorrhoidectomy; inguinal hernia repair; hysterectomy; joint replacement hip or knee; tonsillectomy and/or adenoidectomy; TUR, prostate; varicose vein surgery. Exceptions are made for urgent and emergent cases.

Effective 2-1-81

6.b. Optometry. The following are not covered: anti-glare coating, sunglasses, spare eyeglasses, cosmetic services. For services requiring prior authorization see section HSS 107.20 of the Wisconsin Administrative Code.

Effective 2-1-80

6.c. Chiropractic. Consultations are not covered. For services that require prior authorization, see section HSS 107.15 Wisconsin Administrative Code.

6.d. Other Practitioners. Not provided, except for evaluations of up to four hours per year.

7. Home Health Care Services.

c. Medical Supplies and Equipment. For limitations on services, see section HSS 107.24 of the Wisconsin Administrative Code.

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1. first procedure at 100%;

2. second procedure at 50%;

3. third procedure at 25%;

4. fourth procedure at 12.5%.

Additional surgical procedures performed on the same foot within 120 days of the original surgery will be paid at 50%. Post-operative care, office calls and dressings are considered part of the surgical fee.

(f) The administration of antibiotics is limited to LA, AP, or penicillin for the purpose of treating cellulitis or an acute "itis" associated with foot disease.

(g) Debridement of mycotic conditions and mycotic nails are a covered service per utilization guidelines established by the department of health and social services.

(h) The application of unna boots is allowed once per two weeks.

(3) NON-COVERED SERVICES. The following are non-covered services (in addition to HSS 107.03):

(a) Procedures which do not relate to the diagnosis or treatment of the ankle and foot are not covered.

(b) Palliative or maintenance care, except as enumerated in subsection (2) above.

(c) Orthopedic shoes and supportive devices such as arch supports, shoe inlays, and pads.

(d) Services directed toward the care and correction of "flat feet."

(e) Treatment of subluxation of the foot.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

6.c. HSS 107.15 Chiropractic services. (1) *Covered services.* Chiropractic services which are covered by the medical assistance program are manual manipulations of the spine used to treat a subluxation, and certain specific diagnostic services. Such services shall be performed by a chiropractor certified pursuant to section HSS 105.21.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02(3).]

(a) Prior authorization is required for services beyond the initial visit and 28 manipulations during a 12 month period per recipient per episode of illness as defined in HSS 107.15 (3) (a). The prior authorization request must include a justification of why the condition is chronic and why it warrants the scope of service being requested.

(b) Spinal supports which have been prescribed by a physician or chiropractor are a covered service. If the purchase or rental price of the support is over $75.00, prior authorization is required. Rental costs under $75.00 will be paid for one month without prior approval.

(3) OTHER LIMITATIONS. (a) An x-ray or set of x-rays (such as anterior-posterior and lateral) is a covered service once per episode of illness

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if the x-ray (s) is performed either in the course of diagnosing a spinal subluxation or in the course of verifying symptoms of other medical conditions beyond the scope of chiropractic. (Episode of illness is defined as either the acute onset of a new condition or re-occurrence of a preexisting condition which limits the functional ability of the recipient and requires a sequence of chiropractic adjustments to rectify).

(b) A diagnostic laboratory test is a covered service for an initial office visit only; or when related to the diagnosis of a spinal subluxation; or when verifying a symptomatic condition beyond the scope of chiropractic. The only test covered is urinalysis, when used solely for assessing the possible existence of underlying medical conditions (i.e. diabetes, infections).

(c) The billing for an initial office visit must clearly describe all procedures performed to insure accurate reimbursement.

(4) NON-COVERED SERVICES. Consultations (second opinions) between providers regarding a diagnosis of treatment are not a covered service.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.16 Physical therapy. (1) *Covered services.* Covered physical therapy services are those medically necessary modalities, procedures and evaluations enumerated in this section, when performed by or under the supervision of a qualified physical therapist and when prescribed by a physician. Reimbursement for covered physical therapy services shall be based on the treatment unit (s) performed.

(a) *Evaluation.* Covered evaluations are those enumerated in the list below: (A written report of the results of the evaluation performed shall accompany the test chart or form in the recipient's medical record.)

1. Stress test;
2. Orthotic check-out;
3. Prosthetic check-out;
4. Functional evaluation;
5. Manual muscle test;
6. Isokinetic evaluation;
7. Range of motion measure;
8. Length measurement;
9. Electrical testing:

a. Nerve conduction velocity;

b. Strength duration curve—chronaxie;

c. Reaction of degeneration;

d. Jolly test (twitch tetanus);

e. "H" test;

f. Electro-myography;

required, or when 60 treatment days have been exhausted, whichever comes first.

(c) A spell of illness must be documented in the plan of care.

(d) Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(e) With proper documentation, the department may approve prior authorization requests for up to a year of preventive/maintenance speech therapy.

(f) Treatment days covered by Medicare or other third-party insurance shall be included in computing the 60-day total.

(g) To the extent that the legislature appropriates sufficient funds and position authority, the department will have on its staff qualified speech therapist (s) to review prior authorization requests and perform other consultative activities.

(h) A peer review committee will serve to assist in review of claims and prior authorization requests, to advise the department and to act as first level of an appeal mechanism.

(3) OTHER LIMITATIONS. The limitations of HSS 107.16 (3) apply to speech pathology services.

(4) NON-COVERED SERVICES. (a) Services which are of questionable therapeutic value in a program of speech pathology shall not be covered. For example, charges by speech pathology providers for "language development—facial physical," "voice therapy—facial physical" or "appropriate outlets for reducing stress" shall not be covered.

(b) Activities not associated with the treatment of a recipient, such as the end of day clean up of the treatment area, shall not be reimbursable services.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.19 Audiology. (1) *Covered services.* Covered audiology services are those medically necessary diagnostic, screening, preventive or corrective audiology services prescribed by a physician and provided by or under the supervision of an audiologist certified pursuant to section HSS 105.31. Such services include:

(a) Audiological evaluation;

(b) Hearing aid evaluation;

(c) Hearing aid performance check;

(d) Audiological tests;

(e) Audiometric techniques;

(f) Impedance audiometry;

(g) Aural rehabilitation;

(h) Speech and audio therapy.