

APPENDIX G

COVERED & NON-COVERED SERVICES

Services When Provided, Would be Covered by the Capitation ^{1, 2}	Non-Covered Services; Excluded from the Capitation; Can Be Billed Fee-For-Service
Care Management	Inpatient Hospital Services
Nursing Home Care (Residential Health Care Facility)	Outpatient Hospital Services
Home Care Nursing Home Health Aide Physical Therapy (PT) Occupational Therapy (OT) Speech Pathology (SP) Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home. ³
Adult Day Health Care	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME – including Medical/Surgical Supplies, Enteral and Parenteral Formula, ⁴ and Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Social Care Network	Chronic Renal Dialysis
Podiatry	Mental Health Services
Dentistry	Alcohol and Substance Abuse Services
Optometry/Eyeglasses	OPWDD Services
PT, OT, SP or other therapies provided in a setting other than a home. Limited to 40 visits of physical therapy and 20 visits each for OT, SP and other therapies per calendar year, except for children under 21 and the developmentally disabled. ⁵ MLTC plan may authorize additional visits.	Family Planning Services
Audiology/Hearing Aids	Prescription and Non-Prescription Drugs, Compounded Prescriptions
Respiratory Therapy	All other services listed in Title XIX State Plan
Nutrition	
Private Duty Nursing	
Consumer Directed Personal Assistance Services	
Community First Choice Option services ⁶	
Services Provided Through Care Management:	
Home Delivered or Congregate Meals	
Social Day Care	
Social and Environmental Supports	

¹ The capitation payment includes applicable Medicare coinsurance and deductibles for benefit package services.

² Any of the services listed in this column, when provided in a diagnostic and treatment center, would be included in and covered by the capitation payment.

³ Includes nurse practitioners and physician assistants acting as “physician extenders.”

⁴ Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.

⁵ Effective July 1, 2018. ⁶ Effective upon notification from the Department.