

AMENDED IN ASSEMBLY APRIL 2, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

**ASSEMBLY BILL**

**No. 131**

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**Introduced by Assembly Member Corbett**

January 22, 2001

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An act to amend Section 14133 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 131, as amended, Corbett. Medi-Cal: utilization controls.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Under the Medi-Cal program, benefits are listed on a basic schedule subject to utilization controls determined by the Director of Health Services. Utilization controls include restrictions on the number of services within a specified timeframe.

This bill would provide that, *with respect to specified services*, the limit on services may not be less than 24 visits in one calendar year and may not be limited by timeframes within that calendar year.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 14133 of the Welfare and Institutions
- 2 Code is amended to read:

1 14133. Utilization controls that may be applied to the services  
2 set forth in Section 14132 which are subject to utilization controls  
3 shall be limited to:

4 (a) Prior authorization, which is approval by a department  
5 consultant, of a specified service in advance of the rendering of  
6 that service based upon a determination of medical necessity. Prior  
7 authorization includes authorization for multiple services which  
8 are requested and granted on the basis of an extended treatment  
9 plan where there is a need for continuity in the treatment of a  
10 chronic or extended condition.

11 (b) Postservice prepayment audit, which is review for medical  
12 necessity and program coverage after service was rendered but  
13 before payment is made. Payment may be withheld or reduced if  
14 the service rendered was not a covered benefit, deemed medically  
15 unnecessary or inappropriate. Nothing in this subdivision shall  
16 supersede the claims processing deadlines provided by Section  
17 14104.3.

18 (c) Postservice postpayment audit, which is review for medical  
19 necessity and program coverage after service was rendered and the  
20 claim paid. The department may take appropriate steps to recover  
21 payments made if subsequent investigation uncovers evidence that  
22 the claim should not have been paid.

23 (d) Limitation on number of services, which means certain  
24 services may be restricted as to number within a specified  
25 timeframe. The limitation on services may not be less than 24 visits  
26 in one calendar year and may not be limited by timeframes within  
27 that calendar year *for the following services: chiropractic,*  
28 *acupuncture, psychology, occupational therapy, speech*  
29 *pathology, audiological, podiatry, and prayer or spiritual healing.*

30 (e) Review of services pursuant to Professional Standards  
31 Review Organization agreements entered into in accordance with  
32 Section 14104.

