

## CATEGORIES OF CARE

Established categories of care (19 CSR 40-1.030) are in place and provide guidance when determining eligibility. DHSS Executive Management authorizes which categories of care are considered open to participants for service coordination services and limited funding of direct care services. Budgetary considerations and eligibility for services may be imposed at the discretion of DHSS at anytime. Information regarding impending restrictions and/or eligibility requirements will be communicated as soon as possible.

### Category I

Medical conditions requiring immediate life-saving medical treatment. The conditions include, but are not limited to:

- Burn care - requires grafting,
- Cardiac care - present at birth (congenital) requiring surgical intervention and/or in acute heart failure,
- Cleft lip and palate care - initial closure only,
- Genito-urinary care - related to congenital deformity, non-surgical care to enhance function,
- Myelomeningocele (Spina Bifida) - surgical closure of myelocele,
- Neurology/Neurosurgery - care for depressed skull fractures, uncontrolled seizures, shunting procedures,
- Orthopedic care - care for acquired amputations, vertebral column fractures and dislocations with or without associated spinal cord injury, osteogenesis imperfecta, open complex fractures, infections of the bones,
- Pediatric surgery care - surgical procedures to repair congenital deformities which affect functioning, procedures to restore/improve functioning after severe injury.

#### Conditions not covered under Category I:

Cerebral Palsy; Juvenile Arthritis; Ear, Nose, Throat (ENT) care including hearing care, ENT surgical care, and rehabilitation care.

### Category II

Medical conditions, which if not treated, could worsen or cause a crippling disability. A good prognosis should be expected. Conditions include, but are not limited to:

- Conditions covered in Category I,
- Arthritis care,
- Burn care - follow up and rehabilitation services,
- Cardiac care - not necessarily requiring surgical intervention and is not in cardiac failure,
- Cerebral palsy - surgical care and bracing,
- Cleft lip and palate care - surgical procedures (no orthodontia),
- ENT - surgical procedures requiring specialty care,

- Genito-urinary care - surgical procedures to correct abnormalities of the genital areas,
- Neurology care - care for the late effects of viral disorders affecting the physical and cognitive functional status,
- Neurosurgery - vascular surgeries to improve functioning of the central nervous system,
- Orthopedic care - congenital deformities, late effects of complicated fractures, club feet, non-malignant bone tumors,
- Pediatric surgery care - benign tumors, hemangiomas, lymphangiomas, and neurofibromas all of which must cause functional impairment or disfigurement,
- Spina bifida - rehabilitation services.

Conditions not covered under Category II:

ENT/hearing care.

### **Category III**

Conditions that may require prolonged outpatient care and have a fair prognosis if treated include, but are not limited to:

- Conditions covered in Category I and II and associated follow-up care,
- Cerebral palsy - rehabilitation care,
- Cleft lip and palate - surgical care, orthodontia and speech therapy,
- ENT- surgical procedures including hearing care.

### **Category IV**

Medical conditions having a poor to fair prognosis or uncertain restoration regardless of treatment. This is primarily a category for service coordination.

### **Category V**

Medical diagnosis with a variable prognosis; enhancements allow improvements in activities of daily living, and physical appearance for psychological reasons including craniofacial anomalies (disfiguring facial conditions). If funding allows and budgetary restrictions are not in place, cosmesis (procedures affecting the appearance), inborn errors of metabolism, and special counseling would be considered in this category.

*All categories may have funding ceilings and limitations imposed, and may be categorically suspended. Some conditions have restrictions for coverage and require a clinical review by the Program Manager to be enrolled. Conditions are reviewed on a case-by-case basis to determine if a clinical review needs to be conducted.*

*Limited funding cannot exceed \$25,000.00 (twenty-five thousand dollars) per participant per state fiscal year beginning July 1 of each year. The funding limit is subject to available funds.*