

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPES OF SERVICE	PROGRAM COVERAGE**	AUTHORIZATION AND OTHER REQUIREMENTS*
<p>5b Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C. Section 1396(a)(5)(B), are covered.</p>	<p>In accordance with 42 U.S.C. Section 1396d(a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.</p>	<p>Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for the above service performed by an enrolled dental provider. Prior authorization of a defined subset of the above service is required.</p>

Prior Authorization is not required for emergency services.

**Coverage is limited to medically necessary services

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5a Physician's Services
(continued).

The total number of physician office and clinic visits for physician services provided by a licensed physician, or other medical professional under the direction of a licensed physician, that are covered benefits are limited to seven visits per beneficiary, per fiscal year. The following are not subject to the seven visit limit:

- Specialty mental health provided via the 1915(b) waiver for these services.
- Pregnancy-related visits and visits for the treatment of other conditions that might complicate the pregnancy.
- Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.
- Beneficiaries receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).
- Beneficiaries receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including an ICF/DD Habilitative and ICF/DD Nursing.
- Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE).
- Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation.

Other requirements include:

For physician office and clinic visits in excess of the seven visit limit, a licensed physician, or other medical professional under the direction of a licensed physician, must attest in a written declaration that the services meet one or more of the following circumstances:

- Prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.
- Prevent deterioration in a beneficiary's condition that would otherwise result in an inpatient admission.
- Prevent disruption in ongoing medical and/or surgical therapy, including, but not limited to, medications, radiation, or wound management.
- Constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.
- Are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.