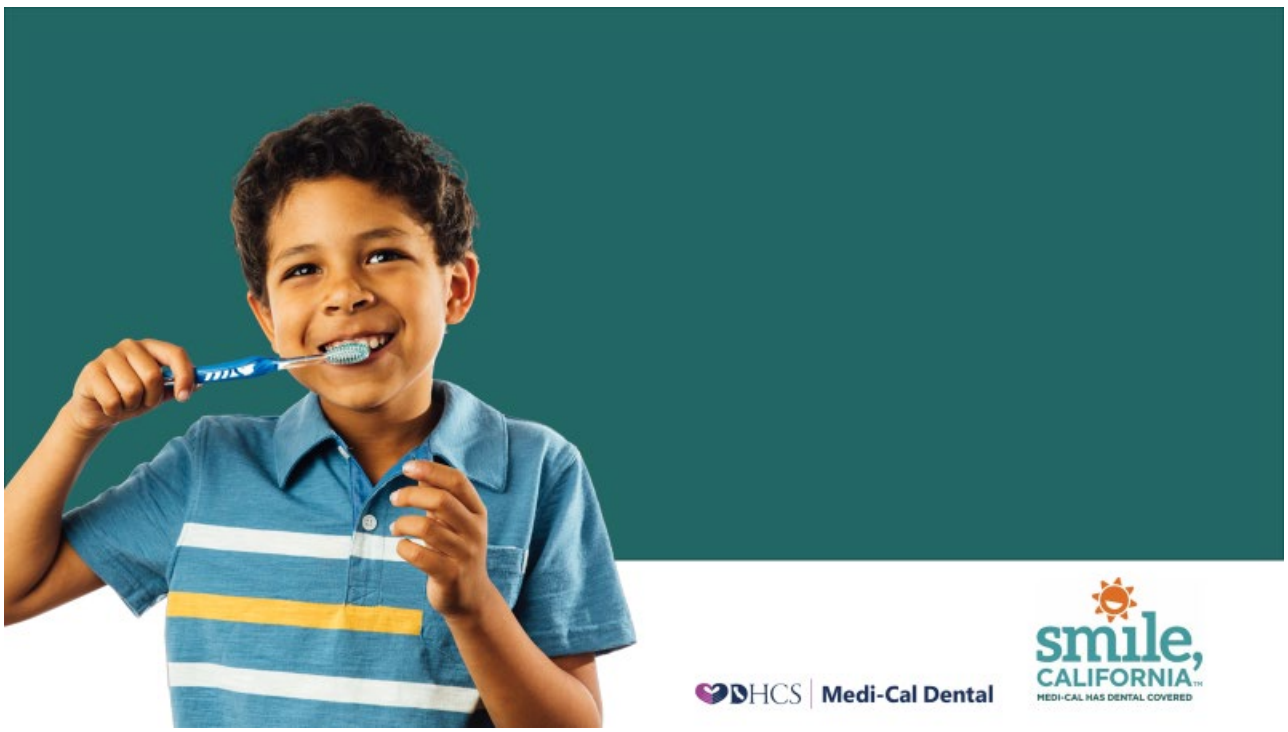
The Advanced Medi-Cal Dental Seminar



Revised 09/23/2020

DHCS | Medi-Cal Dental

Dear Medi-Cal Dental Provider and Staff:

Welcome! This seminar has been designed for dental providers and office staff who participate in the California Medi Cal Dental Program.

The material contained in the training packet has been prepared to help familiarize you with the Medi-Cal Dental Programs' policies, procedures and billing requirements. You should also refer to the Medi-Cal Dental Program Provider Handbook, located on the Medi-Cal Dental Program website at www.dental.dhcs.ca.gov for additional information.

We hope that you will benefit from the information presented at today's seminar. If you have any questions, please call our provider toll-free line at (800)-423-0507.

Sincerely,

Medi-Cal Dental Program

Training and Education

- Free statewide seminars offering CE credits for attendees
- A Toll-free Telephone Service Center (TSC) to quickly answer inquiries on a variety of topics
- Outreach activities designed to distribute program education and promote dentist access in all areas of California
- Participating providers may access the Medi-Cal Dental Provider Handbook (a comprehensive manual), monthly bulletins and other informational materials directly from the Medi-Cal Dental website at www.dental.dhcs.ca.gov

Billing and Payment

- Electronic deposit of Medi-Cal Dental payment checks directly into a bank account assures timely availability of funds
- Automated processing and faster payment of more Medi-Cal Dental claims due to simplified prior authorization and billing requirements
- All billing forms needed for Medi-Cal Dental processing are free of charge and are sent directly to the provider's office
- The ability to submit billing forms, radiographs and attachments electronically through Medi-Cal Dental's EDI (Electronic Data Interchange)

CUSTOMER SERVICE

✓ Medi-Cal Dental Referral System:

Helps increase a patient base by connecting providers with Medi-Cal members who need dental care

✓ Telephone Service Center (TSC):

A special toll-free telephone line with friendly, knowledgeable representatives to answer questions about Medi-Cal Dental

✓ Interactive Voice Response System (IVR):

May be used for quick inquiries, such as; patient history, billing criteria, Medi-Cal Dental enrollment, upcoming seminar information, Medi-Cal Dental payment information or year-to-date earnings

✓ On-site Visit:

Upon request, an on-site visit may be scheduled in the provider's office and a Medi-Cal Dental representative will assist you with billing and processing problems (subject to approval)

GENERAL PROGRAM INFORMATION

Provider Participation in the California Medi-Cal Dental Program

To receive payment for dental services performed for eligible Medi-Cal members, prospective providers must apply and be enrolled with active status to participate in the California Medi-Cal Dental Program. The Medi-Cal Dental Provider Enrollment Department assigns each dental provider a Medi-Cal Dental Provider Number [this number will be the National Provider Identifier (NPI) number that the enrollee obtained from NPPES for their type of business]. The number will be used to identify the provider throughout the claims processing system. The Provider Enrollment Department also:

- Accepts and verifies all applications for enrollment in the California Medi-Cal Dental Program
- Makes changes to Medi-Cal Dental provider name and address records
- Updates the enrollment status of providers for Medi-Cal Dental records

Additionally, all dentists under a billing provider are required to be enrolled as rendering providers in the Medi-Cal Dental program, prior to performing services on Medi-Cal Dental members.

To obtain an application for enrollment, report name and address changes, or to obtain information concerning your current enrollment status, contact:

Medi-Cal Dental Program, Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

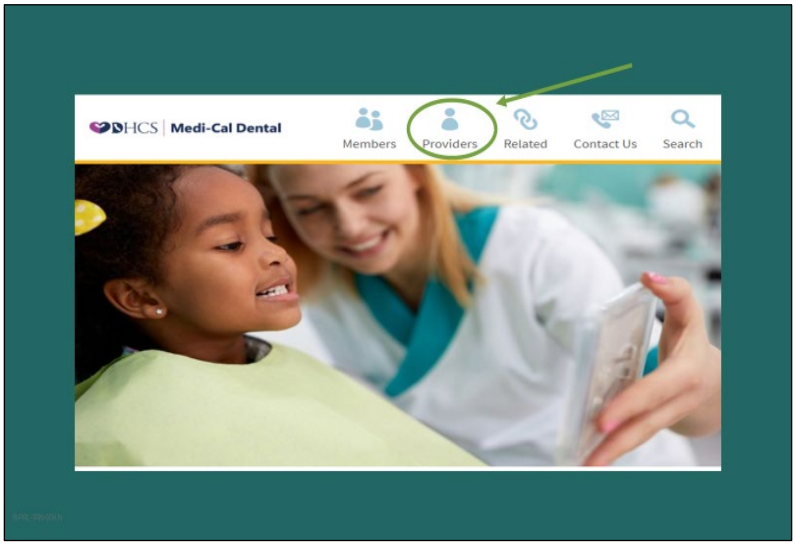
Enrollment forms are also available online at the Medi-Cal Dental web site:
www.dental.dhcsca.gov/dental_providers/denti-cal/provider_forms/

Voluntary Termination of Provider Participation

A provider may terminate participation in the California Medi-Cal Dental Program at any time. Written notification of voluntary termination must be made to the above address.

Suspended and Ineligible Providers

The State Department of Health Care Services may suspend and inactivate the participation of a dental provider in accordance with the regulations contained in Article 1 (commencing with Section 51000.53) of Division 3, Title 22 of the California Code of Regulations (CCR). The State notifies Medi-Cal Dental of the suspension or ineligibility of any provider.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Members
Providers
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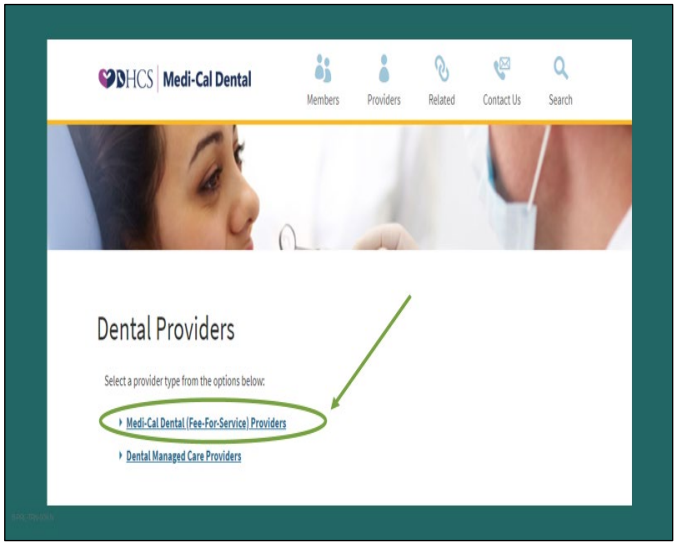
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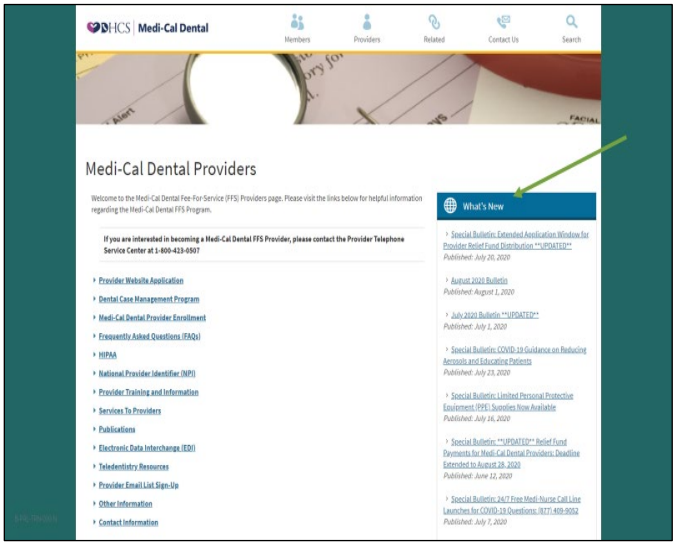
Dental Providers
Select a provider type from the options below:
Medi-Cal Dental (Fee-For-Service) Providers
Dental Managed Care Providers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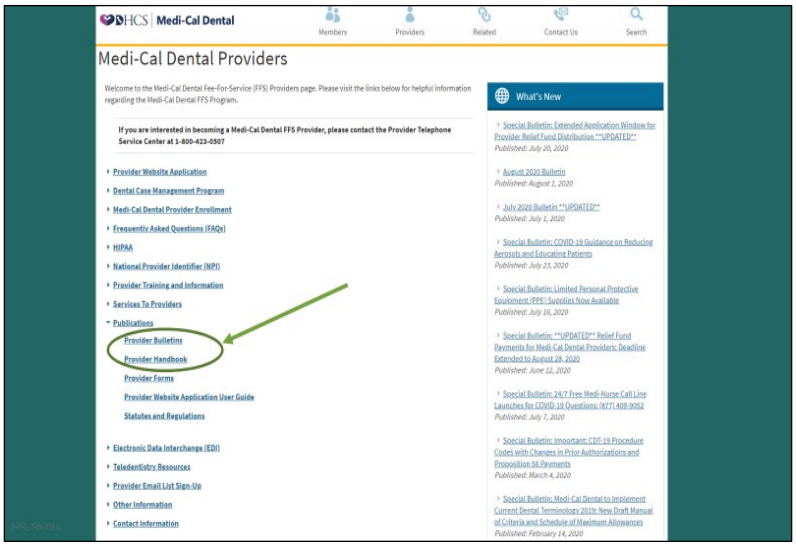
Medi-Cal Dental Providers
Welcome to the Medi-Cal Dental Fee-For-Service (FFS) Providers page. Please visit the links below for helpful information regarding the Medi-Cal Dental FFS Program.
If you are interested in becoming a Medi-Cal Dental FFS Provider, please contact the Provider Telephone Service Center at 1-800-423-0507
Provider Website Application
Dental Case Management Program
Medi-Cal Dental Provider Enrollment
Frequently Asked Questions (FAQs)
HIPAA
National Provider Identifier (NPI)
Provider Training and Information
Services To Providers
Publications
Electronic Data Interchange (EDI)
Teledentistry Resources
Provider Email List Sign-Up
Other Information
Contact Information
What's New
Special Bulletin: Extended Application Window for Provider Relief Fund Distribution **UPDATED**
Published: July 20, 2020
August 2020 Bulletin
Published: August 1, 2020
July 2020 Bulletin **UPDATED**
Published: July 1, 2020
Special Bulletin: COVID-19 Guidance on Reducing Aerosols and Educating Patients
Published: July 23, 2020
Special Bulletin: Limited Personal Protective Equipment (PPE) Supplies Now Available
Published: July 16, 2020
Special Bulletin: **UPDATED** Relief Fund Payments for Medi-Cal Dental Providers: Deadline Extended to August 28, 2020
Published: June 12, 2020
Special Bulletin: 24/7 Free Medi-Nurse Call Line Launches for COVID-19 Questions: (877) 409-9052
Published: July 7, 2020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Members
Providers
Related
Contact Us
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Medi-Cal Dental Providers
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If you are interested in becoming a Medi-Cal Dental FFS Provider, please contact the Provider Telephone Service Center at 1-800-423-0507
Provider Website Application
Dental Case Management Program
Medi-Cal Dental Provider Enrollment
Frequently Asked Questions (FAQs)
HIPAA
National Provider Identifier (NPI)
Provider Training and Information
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Provider Forms
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Statutes and Regulations
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Published: June 12, 2020
Special Bulletin: 24/7 Free Medi-Nurse Call Line Launches for COVID-19 Questions: (877) 409-9052
Published: July 7, 2020
Special Bulletin: Important: CDT-19 Procedure Codes with Changes in Prior Authorizations and Proposition 56 Payments
Published: March 4, 2020
Special Bulletin: Medi-Cal Dental to Implement Current Dental Terminology 2019: New Draft Manual of Criteria and Schedule of Maximum Allowances
Published: February 14, 2020

Program Background

- The Medi-Cal Dental Program is governed by policies subject to the laws and regulations of the Welfare and Institutions (W&I) Code, the California Code of Regulations (CCR), Title 22, and the California Business and Professions Code – Dental Practice Act

Program Background

- Delta Dental of California is the Administrative Services Organization (ASO) for the Department of Health Care Services Medi-Cal Dental Program. The Medi-Cal Dental Program is the dental division of Medi-Cal.
- Additional Information:
  - W&I Code
  - California Code of Regulations (CCR), Title 22
  - California Business and Professions Code
  - The Medi-Cal Dental website (http://dental.dhcs.ca.gov)

B-PRL-TRN-009-M

Program Criteria

- The Manual of Criteria (Provider Handbook, Section 5) is put forth by the Department of Health Care Services (DHCS) and establishes the criteria for the procedures
  - The criteria apply to all providers and members in the Program
  - The Program does make some modifications to the submission requirements

Provider Handbook, Section 5

- Changes that are not yet reflected in the Manual of Criteria (MOC) are outlined in page 1 of Section 5
- Changes in policy can be made through Bulletin Authority

Policy Changes

The following table lists current changes in policy not yet reflected in the Manual of Criteria (MOC).

Procedure Code	Effective Date	Impacted MOC	Bulletin Defining Policy Change
D5212	7/10/2019	Page 5-48	June 2019, Vol. 35, #18
D5211	7/10/2019	Page 5-48	June 2019, Vol. 35, #18
D2710-D2792	3/1/2019 and 7/10/2019	Pages 5-21 and 5-22	June 2019, Vol. 35, #18
D9430	7/10/2019	Page 5-102 and 5-103	June 2019, Vol. 35, #17
D9910	7/10/2019	Page 5-103	June 2019, Vol. 35, #17
D0210	6/1/2019	Pages 5-6 and 5-7	May 2019, Vol. 35, #15
D0340	6/1/2019	Page 5-9	May 2019, Vol. 35, #15
D1206	6/1/2019	Page 5-15	May 2019, Vol. 35, #15
D1208	6/1/2019	Page 5-15	May 2019, Vol. 35, #15
D1320	6/1/2019	Pages 5-15 through 5-16 and 5-109	May 2019, Vol. 35, #15
D1510	6/1/2019	Page 5-16	May 2019, Vol. 35, #15
D1515	6/1/2019	Pages 5-16 and 5-17	May 2019, Vol. 35, #15

Surveillance & Utilization Review Subsystem (S/URS)

- Title 22, California Code of Regulations
  - Record Keeping Criteria for the Medi-Cal Dental Program:
    1. Member treatment records shall be kept, maintained for 10 years from the date of service was rendered and must be readily retrievable upon request
    2. Records shall demonstrate documentation supporting each procedure provided including but not limited to:
       - Type & extent of services, and/or radiographs demonstrating and supporting the need for each procedure provided
       - Indicate type of materials used, anesthetic type, dosage, vasoconstrictor and number of carpules used
       - Prophylaxis and fluoride treatments
       - Include the date and ID of the enrolled provider who performed the treatment
    3. Emergency services must have written documentation which includes, but is not limited to the tooth/area, condition and specific treatment performed. The statement "an emergency existed' is NOT sufficient."

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S/URS

- Provider Bulletin Volume 33, Number 2 (February 2017) reminds providers to avoid "Upcoding," which is billing for more surfaces than were actually restored or for billing for more complex procedures than were performed
- Additional information in -Provider Handbook Section 8 – Fraud, Abuse, and Quality of Care

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Record Keeping Criteria

- Medi-Cal Dental Program submission requirements for prior authorization or payment purposes may differ from the requirements of the Dental Practice act or the Standard of Care

Requirements for Providers

- Billing providers must ensure that all their rendering providers are enrolled in the Medi-Cal Dental program prior to treating Medi-Cal Dental members
  - Payments made to billing providers for services performed by their unenrolled rendering providers will be subject to payment recovery
- Instructions about enrollment are found in the Provider Handbook, Section 3: Enrollment Requirements

Requirements for Providers

- SB 639 – Effective July 1, 2020
- See Bulletin Volume 36, Number 4 (March 2020): Enhanced Protections for Medi-Cal Members
- Contains provisions regarding lines of credit
- Requires that dentist provide a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs

SB 639

- For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment

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Dental Services

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Term Descriptions

- Child
- Adult
- Facility Resident
- Regional Center Consumer (DDS Consumer)
- Pregnant Members

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Child

- Member under the age of 21(0-20)
- Scope of benefits based on aid code

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Adult

- Member aged 21 and older
- Scope of benefits based on aid code
- For treatment that requires prior authorization, the Notice of Authorization (NOA) remains valid for members who reach their 21st birthday during the authorization period

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Facility Resident

- Dental services for members who reside in a
  - SNF – Licensed Skilled Nursing Facility
  - ICF – Licensed Intermediate Care Facility
- Dental services do not have be provided in the facility to be payable for Place of Service (POS) 4 or 5 residents

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Pregnant Members

- Members who are pregnant and up to 60 days postpartum
  - Pregnant members regardless of age, aid code, and/or scope of benefits are eligible to receive all procedures listed in the Manual of Criteria as long as all procedure requirements and criteria are met
  - Prior authorization is waived for D4341/D4342 (Scaling and Root Planing)
  - All radiographic requirements must be met except
    - Bitewing requirements are waived for D4341/D4342 (Covered in Periodontics section of seminar)
    - Arch integrity radiographic requirements waived

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Pregnant Members

- You must document member's pregnancy or postpartum status on each document
- For all procedures that require radiographs, no payment will be made if the radiographs are not submitted. "Member refused x-rays" will not be acceptable documentation for non-submission of radiographs
- California Dental Association (CDA) http://www.cdafoundation.org/education/perinatal-oral-health

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Adjudication Reason Codes (ARCs)

- Adjudication Reason Codes - Handout Page 51
- Provider Handbook Section 7

271B 274 289 123 266G 038 029A

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Emergency Services for Limited Scope Aid Codes

- Emergency Services Only aid codes cover specific emergency procedures, regardless of age
- For details refer to Provider Handbook Section 4

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Questions	Answers
Submission Requirements	
Manual of Criteria	
Benefits – What are the current benefits?	
Benefits – Why is it ***NOT*** a benefit?	
Program Policies	

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Program Criteria

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Criteria Covered Today

- Emergency Services
- Diagnostic Services
- Preventive Services
- Restorative Services
- Endodontic Services
- Periodontal Services
- Removable Prosthodontic Services
- Oral Surgery
- Anesthesia
- EPSDT – Early Periodic Screening Diagnosis and Treatment

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D9110

- Palliative Emergency Treatment of Dental Pain
  - "Hands-On" emergency visit
  - Payable once per date of service
    - Not per procedure or per tooth
  - Requires documentation
  - D0171 can only be billed as D9110 or D9430 and is not payable separately

Documentation

- For emergency procedures and members with Emergency Only Aid Codes, documentation shall include
  1. Chief Complaint
  2. Diagnosis with tooth number or area
  3. The treatment performed

Emergency Documentation

- Emergency Certification Statement signed by the treating dentist is required for members with aid codes for emergency services only
- Paper claims – use Comments Box 34
- EDI Claims – signature requirement waived though documentation must still be present

D0999

- CDT code D0999 will revert to "Unspecified diagnostic procedure, by report" with a SMA reimbursement rate of $46.00, effective May 16, 2020.

D9995 Teledentistry

- Teledentistry – Synchronous; Real-time encounter
- Written documentation for payment shall include the number of minutes that the transmission occurred.
- Payable once per date of service per patient, per provider up to a maximum of 90 minutes.
- Bill number of minutes in the Quantity field on your claim

D9430 - Criteria

- Office Visit for Observation – No Other Services Performed
- A benefit once per member, per date of service, per billing provider
- Not a benefit when rendered in a facility (SNF/ICF)
  - Use D9410 in facility

D9430

- "Hands-Off" visit
- Observation visit only that may include prescribing, reappointing, referral to specialist, etc.
- No documentation required for payment purposes but documentation must be in member record according to Medi-Cal Dental Program guidelines

Recementation

- D2910 Inlay
- D2920 Crown
- D6930 FPD

- Benefit once in 12 Months without radiographs or documentation
- Additional Requests within 12 months require documentation

D2940

- Protective Restoration
- For use as a temporary restoration
  - Requires tooth number
  - Benefit once per tooth per lifetime
  - Requires pre-op radiograph for payment
  - Not a benefit for RCT-treated tooth (use D9110)
  - Not a benefit on the same day as a definitive restoration in the same tooth

D2941

- Interim Therapeutic Restoration – Primary Dentition
  - Requires tooth number – Primary tooth only
  - Benefit once per tooth in a six-month period per provider as a temporary restoration
  - Requires pre-op radiograph for payment
  - Not a benefit on the same day as a definitive restoration in the same tooth
  - Not a benefit for a tooth which has had a pulpotomy
  - Not as benefit as a base or liner under a restoration

D3221

- Pulpal Debridement
  - Benefit for initial Open & Drain – for the relief of acute pain prior to conventional root canal therapy
  - No prior authorization
  - No documentation or radiograph required for payment
  - For permanent teeth or over-retained primary teeth with no successor
  - A benefit once per tooth
  - Not for root canal therapy visits once RCT has been authorized
  - For additional emergency visits use D9110

D7510

- Incision and Drainage of Abscess, Intraoral Soft Tissue
  - Requires written documentation of condition, specific tooth or area, rationale for treatment and any pertinent history
  - Benefit once per quadrant per date of service
  - Not a benefit with other treatment in the same quadrant on the same date of service except for radiographs
  - Fee includes the incision and placement and removal of any surgical draining device

D9910

- Application of Desensitizing Medicament
  - Requires Documentation
    - Tooth or teeth treated
    - Specific treatment provided
  - A benefit once per date of service
  - Permanent teeth only
  - Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose the emergency condition
  - This procedure is considered to be an emergency treatment only

D9440

- Office Visit After Regularly Scheduled Hours
- Documentation required
  - Use the formula for emergency visits
  - Time and day of week required (ARC 267i)
- A benefit to compensate the provider for travel time outside of normal office hours
- A benefit once per member per date of service per provider

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Diagnostic Services

D0145

- Oral Evaluation for a Member Under Age 3 and Counseling with Primary Caregiver
- A benefit under the age of 3
  - D0150 or D0120 not a benefit under age 3
- A benefit once every three months per billing provider

D0150

- Comprehensive Oral Evaluation
- A benefit once per member per billing provider for initial evaluation for members age 3 and older
- Additional D0150 allowable if no D0120 or D0150 paid to same billing provider within previous 36 months

D0120

- Periodic Oral Evaluation
- A benefit once every 6 months per billing provider for members age 3 through 20
  - At least 6 months after D0150 by same billing provider
- A benefit once every 12 months per billing provider for members age 21 and older
  - At least 12 months after D0150 by same billing provider

D0210

- Radiographs – Complete Series (Including Bitewings)
  - Not a benefit under age 11
    - bill individual radiographs
  - Complete series shall be at least one of the following combinations
    - 10 periapicals and bitewings
    - 8 periapicals, 2 occlusals, and bitewings
    - Pano, bitewings, and a minimum of 2 periapicals

D0210

- A benefit once in a 36-month period per billing provider
- Not payable when bitewings have been paid within 6 months to the same provider

D0220 D0230

- Periapical 1st Film, Periapical Each Additional Film
  - Submission of radiographs not required for payment
  - Benefit to a maximum of 20 periapicals in a 12-month period
  - Periapicals taken as part of FMX are not considered against this 20-radiograph limit

D0272 D0274

- Bitewings
  - 2 Films D0272
  - 4 Films D0274
- A benefit once every 6 months per billing provider
- Not a benefit within 6 months of complete series D0210
- D0274 not a benefit under age 10

D0330

- Panoramic Film
- A benefit once in a 36-month period per member per billing provider

D0350 - Photographs

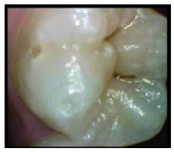
- Photographs must be appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs in order to be payable
- Not a benefit when used for member identification
- Recommended to supplement radiographs when the radiographs do not demonstrate medical necessity

D0350 - Photographs

- Submit photos with the procedure they support
- Maximum of 4 photos payable per date of service
- Additional photos may be submitted to demonstrate medical necessity

- Date on submitted photo must match the date of service on the claim form for the photo being billed
- Date of Service for photo does not need to be the date of service of the restoration

04-15-19 Name #14



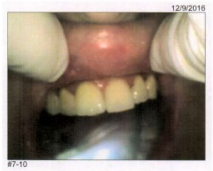
EXAMINATION AND TREATMENT

26. TOOTH # (ER, MOU, QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER
		1 Oral/Facial Photographic Images	4-15-19	1	D0350
14	OL	2 Resin Base Composite - two surfaces, posterior	4-30-19	1	D2392
		3			
		4			
		5			
		6			
		7			

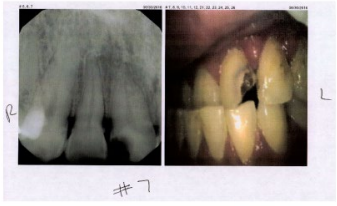
Radiograph and Photograph Submission

- Must be dated and current
- Must include member name
- Must include orientation – indicate tooth # or quadrant/area as needed
- Must be of diagnostic quality

Radiograph and Photograph Submission



- Insufficient orientation



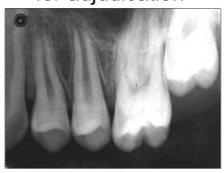
- Opposite orientation on photo and radiograph

Radiograph and Photograph Currency

- What is a current photo or radiograph?
  - Primary tooth – 8 months
  - Permanent tooth – 14 months
  - Arch integrity – 36 months

Undated Photos

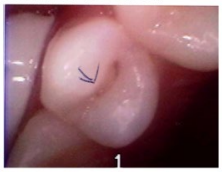
- Undated photos receive ARC 029a and cannot be used for adjudication



First Last #12 6/11/19

Claim for Occlusal Restoration #12; caries not evident on radiograph

Provider sends photo with member name and orientation



First Last #12

missing date

However, photo has no date and cannot be used by consultant

Radiograph/Photograph Tips

- The Medi-Cal Dental Program no longer returns radiographs or photos
- Submit only duplicates – never send your last film to us
- Dental consultants no longer handle physical radiographs, only scans, so duplication must be of high quality to be diagnostic

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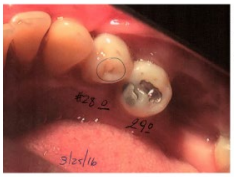
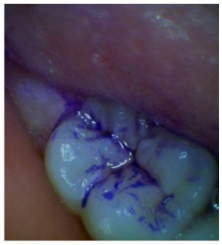
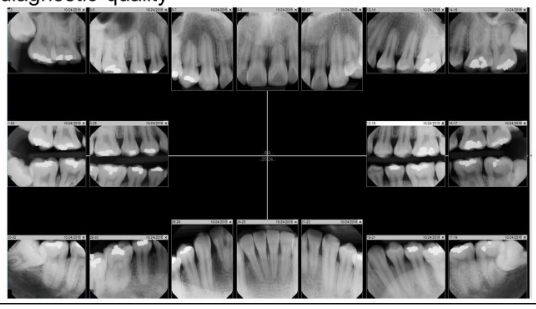


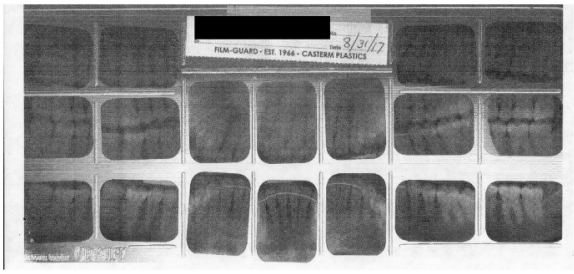
Since images are scanned for the dental consultants, put all labeling information on the front

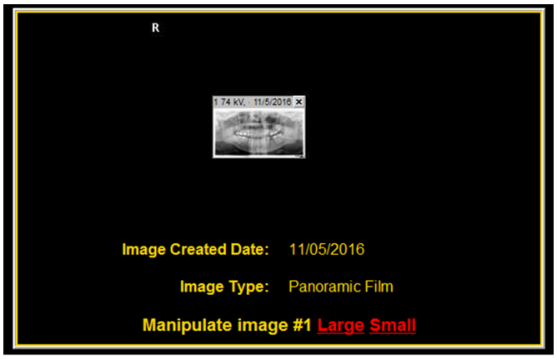


Caries dye renders photos nondiagnostic

- Duplication and radiographic technique must be of diagnostic quality







Arch Integrity

- Arch integrity and overall condition of the mouth, including the member's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5-year prognosis for the teeth or abutments
- Anterior periapical radiographs and bite-wings are enough to establish arch integrity of the arches

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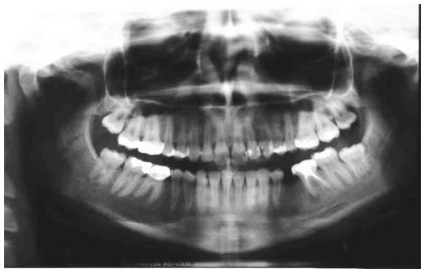
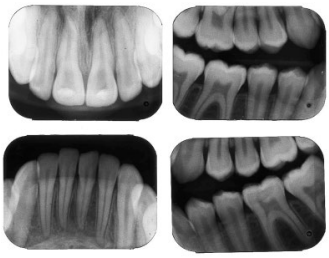
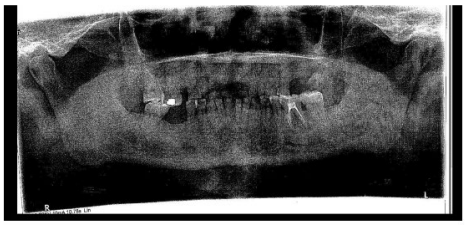
Arch Integrity



Arch Integrity

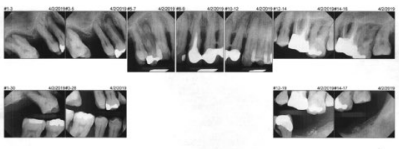


Arch Integrity



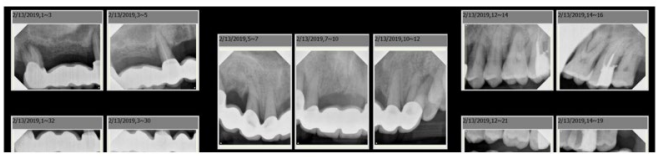
- 266H – Radiographs submitted to establish arch integrity are non-diagnostic

Arch Integrity



- 271C – Arch lacks integrity

Arch Integrity



- 271C – Arch lacks integrity

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Preventive Procedures

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Child – Under Age 6

- Prophylaxis D1120 a benefit once in a six-month period per member without prior authorization
- Fluoride D1206 or D1208 a benefit once in a four-month period

Child – Age 6 Through 20

- Prophylaxis D1120 and Fluoride D1206 or D1208 a benefit once in a six-month period

Adult

- Prophylaxis D1110
- Fluoride D1206 or D1208
- A benefit once in a 12-month period per member without prior authorization
- Note that prophylaxis and scaling & root planing procedure frequencies are per member, not per billing provider

SNF - ICF

- Prophylaxis (D1110 or D1120) and fluoride (D1206 or D1208) are a benefit one in a four-month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility

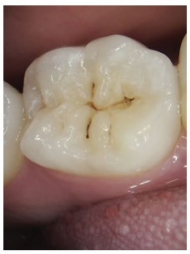
D1351 - Sealant

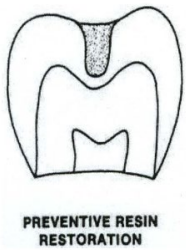
- Benefit under age 21 for 1st and 2nd permanent molars
- No prior authorization, radiographs, or documentation
- On claim form, indicate tooth number and surface(s) being sealed
- Occlusal surface must be sealed, must be caries free, and must be restoration free
- Original provider responsible for replacement for 36 months

D1352 – Preventive Resin

- Benefit under age 21 for 1st and 2nd permanent molars
- No prior authorization, radiographs, or documentation
- Only for active carious lesion in a pit or fissure that does not cross the DEJ
- Original provider responsible for replacement for 36 months

D1352





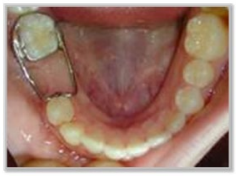
D1320

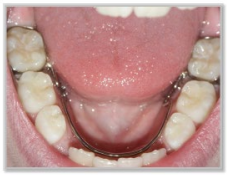
- Tobacco Counseling for the Control and Prevention of Oral Disease
- Submission of dental record documentation is not required for payment
- A benefit only in conjunction with an exam (D0150 or D0120)

D1320

- Documentation in the provider record of a face-to-face encounter shall include:
  - The five A's of tobacco dependence – Ask, Advise, Assess, Assist, Arrange. If unwilling to quit document the patient's expressed roadblocks
- Provider bulletin – May 2019 (Vol 35, Number 15)
  - https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_15.pdf

Space Maintainers





Space Maintainers

- Prior authorization not required
- Requires pre-operative radiograph(s)
- Arch/quadrant code
- Indicate missing primary molar(s)
- Not a benefit for anterior teeth

Unilateral Space Maintainers

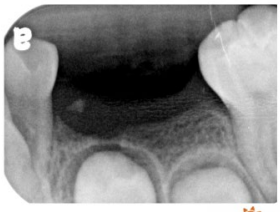
- Fixed, D1510
- Removable, D1520 – this procedure is no longer a benefit
- Quadrant code required
- Indicate missing primary molar
- Pre-op radiograph required

Unilateral Space Maintainers

- A fixed unilateral space maintainer is only a benefit to maintain the space of a single primary molar
- ARC 197a
- Bilateral space maintainer indicated

Bilateral Space Maintainers

- Fixed, D1516 Maxilla
- Fixed, D1517 Mandible
- Removable, D1526 Maxilla
- Removable, D1527 Mandible
- Arch code required
- Indicate missing primary molars

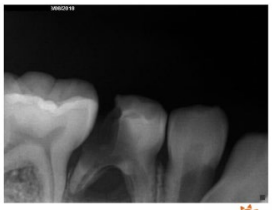


Bilateral Space Maintainers

- Pre-op radiograph or radiographs required
  - More than one radiograph if molars missing on opposite sides
- Bilateral space maintainers shall be attached to teeth on both sides of the arch
- All clasps, rests, and adjustments included in fee

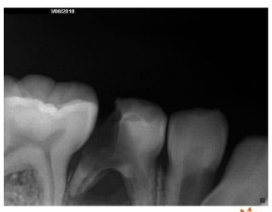
Space Maintainer Radiographs

- Should depict adequate space
- Premolar not near eruption

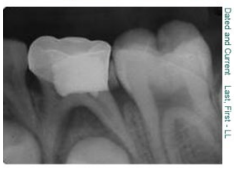


Space Maintainer Radiographs

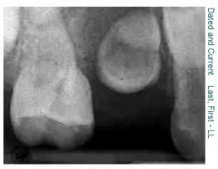
- Should depict adequate space
- Premolar not near eruption



Space Maintainer Radiographs



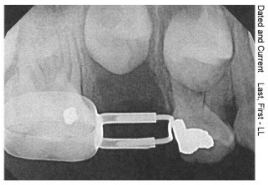
- Before the extraction



- After extraction but before placement of space maintainer

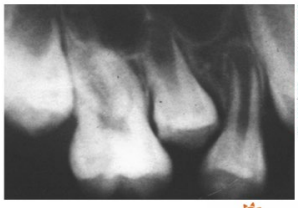
Space Maintainer Radiographs

- 029E
  - Payment denied due to date of radiograph/photograph is after the date of service or appears to be post-operative



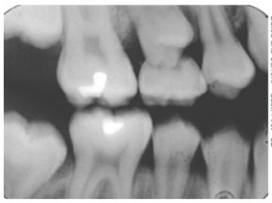
Adjudication Reason Code 191

- Insufficient space for eruption



Adjudication Reason Code 192

- Permanent tooth near eruption



Space Maintainer Replacement

- Space maintainers are a benefit once per lifetime
- Replacement requires documentation and current radiograph

Space Maintainer Recementation

- D1550
- Requires quadrant or arch code as appropriate
- A benefit once per billing provider without documentation
- Additional recementation procedures require documentation
- A benefit under age 18

Space Maintainer Removal

- D1555
- Requires quadrant or arch code as appropriate
- No documentation or radiographs required
- Not a benefit to original billing provider – removal included in fee for placement

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Restorative Procedures

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Restorative Procedures

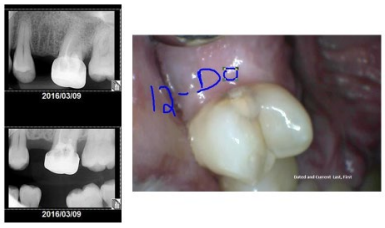
- For amalgams, composites and prefabricated crowns:
  - Prior authorization not required – submit on a claim
  - Submission of pre-operative radiographs not required for payment, with the following exceptions:

Restorative Radiographs Required

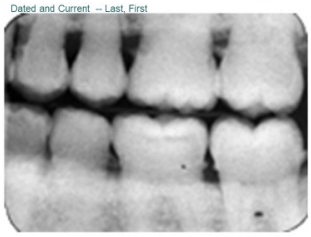
- Anterior proximal restoration (amalgam/composite) when submitted as a two- or three-surface restoration
- Replacement restoration by the same provider
  - Primary teeth within the first 12 months
  - Permanent teeth within the first 36 months
  - Payable when replacement is beyond the control of the provider
    - Loss of restoration, fracture, recurrent caries
  - A replacement restoration is: same tooth, same surfaces

Use of Photos

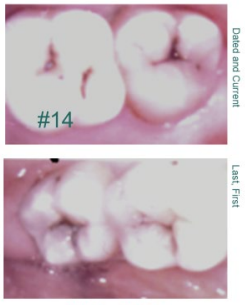
- When radiographs fail to demonstrate need, submit photographs as additional documentation



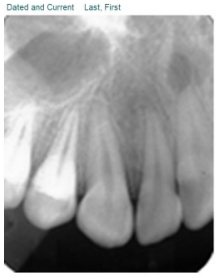
#12 DO



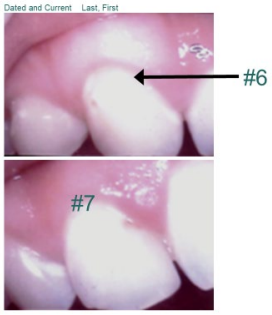
#14-O, #15-O
#18-OB, #19-OB



#18, #19



#6-F, #7-F



Restorative Procedures

- When radiographs are required, unacceptable documentation for lack of radiographs includes
  - Patient/parent refused radiographs
  - Cannot take radiographs because provider does not have access to portable x-ray unit
  - Unmanageable or uncooperative

Senate Bill 1403

- Effective January 1, 2007
- Applies to members under four years of age, or
- Regardless of age, has a developmentally disability, as defined in W&I Code section 4512.
  - Provider must establish and document that the member is a registered consumer of the Department of Developmental Services

Senate Bill 1403

- One current diagnostic radiograph or photograph showing caries on at least one tooth surface will be sufficient for payment of all restorations and prefabricated crowns
- The requirement for arch films will be waived for prefabricated crowns on permanent teeth

Amalgam/Composite Codes

Surfaces	Amalgam	Posterior Composite	Anterior Composite
One Surface	D2140	D2391	D2330
Two Surfaces	D2150	D2392	D2331
Three Surfaces	D2160	D2393	D2332
Four or More Surfaces	D2161	D2394	D2335

D2161, D2394, or D2335 are the maximum paid for amalgam or composite restorations placed in a single tooth on the same date of service

Amalgams and Composites

- Surfaces listed on the same CSL are considered connected
- Non-connected restorations on the same tooth for the same date of service shall be submitted on separate CSLs
- Example: Tooth #8
  - MI D2331 + DI D2331 performed on same Date of Service
  - Will be paid as MID – D2332

Amalgams and Composites

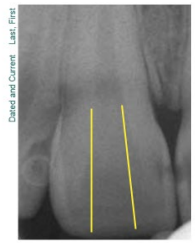
- Separate restorations on the same tooth are allowable when different materials are used
- Example: Tooth #3
  - MOD Amalgam D2160
  - B Composite D2391
  - Both restorations payable

Amalgams and Composites

- Two separate single surfaces payable on a tooth when surfaces are non-adjacent
- Example: #8
  - D2330 M Composite
  - D2330 D Composite
  - Both are payable

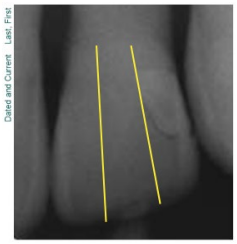
Anterior Composites

- A proximal restoration is paid as a single surface in anterior teeth unless the caries extends 1/3 the width of the clinical crown
- The radiographs must justify the request
- Photos may be submitted along with the radiograph



Tooth # 8

MFL Paid as a single surface - **D2330**

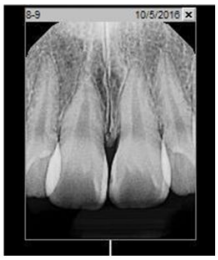


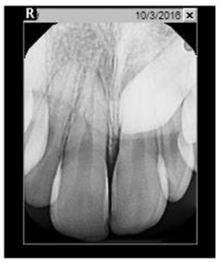
Tooth # 10

DF or DL - 1/3 Facial **or** Lingual involved Payable as a two surface - **D2331**

DFL - 1/3 Facial **&** Lingual involved Payable as a two-surface and three-surface- **D2332**

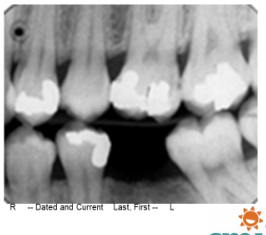
ARC 266L





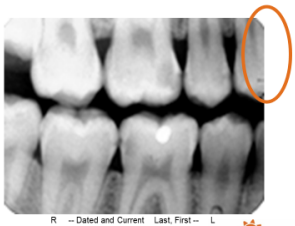
ARC 121

- Radiographs do not substantiate immediate need for restoration of surface(s) indicated
- #14 MODL – Payable
- #13 DO – Denied 121



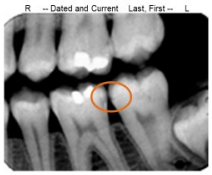
ARC 123

- Radiograph does not depict the entire crown/tooth
- When a restoration is reviewed, the dental consultant must see both interproximal surfaces
- #5 DO – Denied 123

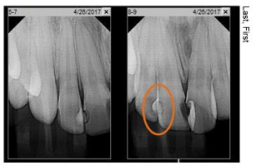


ARC 124

Additional surfaces require treatment



#19 DO - Payable
#18 O - Denied **124**



#8 - ML Denied **124**

Restorative Procedures

- If bitewings are submitted and the destruction appears to encroach upon the pulp, submit a PA radiograph fully depicting the apex/apices
- When restorative procedures are reviewed, PA radiographs are required for endodontically treated permanent teeth

Crowns

Laboratory-Processed Crowns

- Requires prior authorization
- Tooth #
- PA Radiograph of entire tooth
- Post-Endo film (if applicable)
- Radiographs to demonstrate arch integrity if age 21 or older
  - Waived if RCT completed within past six months
- Resin (Indirect) – D2710, D2712, D2721
- Porcelain – D2740
- Porcelain fused/predominantly base metal – D2751
- ¾ Crowns D2781, D2783
- Cast base metal – D2791

Lab Crown Policies

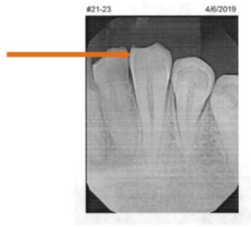
- A benefit once in a 5-year period
- Not a benefit for
  - members under age 13
  - 3rd molars unless the tooth first meets the criteria and is occupying the 1st or 2nd molar position
- Noble metals are not a benefit
- Payment is made upon final cementation; there is no partial payment provision for crowns
- A benefit for endodontically treated premolars and molars for members under 21 years old

Lab Crowns - Anterior

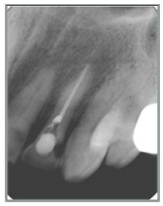
- Involvement of four or more surfaces including an incisal angle, or
- Destruction of more than 50% of the anatomical crown

Lab Crowns - Anterior

- Denied



- Allowed even without incisal edge involvement due to greater than 50% destruction of anatomical crown

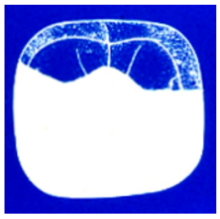


Lab Crowns - Premolar

- 3 surfaces including 1 cusp involved

Lab Crowns - Molar

- 4 surfaces including 2 cusps involved

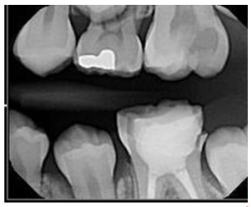


ARC 113, 113A

- ARC 113 – tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment
- ARC 113A – Per history, radiographs, or photographs it has been determined that this tooth has been recently restored with a restoration or prefabricated crown

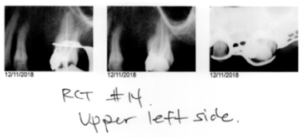
ARC 113B

- Per radiographs, the tooth/eruption pattern is developmentally immature. Please re-evaluate for alternate treatment



ARC 113C

- This ARC applies to posterior lab crowns in members age 21 and older
- The tooth must meet existing criteria and serve as an abutment for a cast RPD
- If not a cast RPD abutment, alternative treatment includes prefabricated crown, amalgam or composite restoration, or private-pay arrangement for lab crown



D2952 – D2954

- Cast or prefabricated post & core do not require prior authorization
- Requires tooth number, PA radiograph, and arch integrity radiographs (age 21 and older)
- Tooth must be endodontically treated
- A benefit only in conjunction with allowable prefabricated or lab crowns – the crown must have been paid or authorized by the Program

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Prefabricated Crowns

Prefabricated Crowns

- Stainless Steel (Primary tooth) – D2930
- Stainless Steel (Permanent tooth) – D2931
- Resin (Primary or Permanent tooth) – D2932
- Stainless Steel with Resin Window (Primary or Permanent tooth) – D2933

Prefabricated Crowns – Primary Teeth

- Prior authorization is not required
- Tooth # required
- A benefit once in a 12-month period

Prefabricated Crowns – Primary Teeth

- To qualify for a prefabricated crown, a primary tooth must demonstrate:
  - Three or more tooth surfaces involved or
  - Extensive two-surface interproximal restoration or
  - In conjunction with pulpotomy

Prefabricated Crowns – Permanent Teeth

- D2931, D2932, D2933
- Prior authorization not required
- Tooth # required
- A benefit once in a 36-month period

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Endodontics

D3220

- Therapeutic pulpotomy, primary tooth
  - No prior authorization, documentation, or radiograph required
  - A benefit once per tooth

D3230 D3240

- Pulpectomy, primary tooth
  - No prior authorization, documentation, or radiograph required
  - A benefit once per tooth

D3310 D3320 D3330

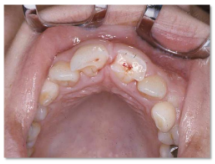
- Initial root canal therapy
  - Prior authorization not required for children
    - Can be submitted on claim – no radiographs required for payment
  - Prior authorization is required for adults
  - Requires a periapical depicting entire tooth
    - Also requires arch integrity radiographs for adults
  - Tooth will be evaluated for longevity, periodontal status, and restorability

D3310 D3320 D3330

- Not a benefit for 3rd molars unless occupying the 1st or 2nd molar position
- Date of service on NOA is final treatment date
- Post-treatment radiograph not required for payment
  - Documentation and appropriate radiographs must still be maintained in the treatment record in accordance with Standards of Care
- Fee includes
  - All treatment and post-treatment radiographs
  - Temporary restoration

D3310 D3320 D3330

- Prior authorization may be waived when one of the following has occurred
  - Tooth has been accidentally avulsed
  - Crown fracture has exposed vital pulp tissue

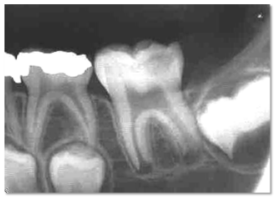


D3346 D3347 D3348

- Root canal re-treatment
  - Same prior authorization guidelines as initial root canal therapy
  - Requires written documentation including rationale for treatment (if not evident on radiograph)
  - Not a benefit to original provider within 12 months of initial treatment

D3222

- Partial Pulpotomy for Apexogenesis
  - For vital permanent teeth with incomplete root development
  - A benefit once per tooth
  - Under age 21
  - Requires
    - Prior authorization
    - PA radiograph

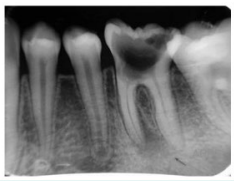
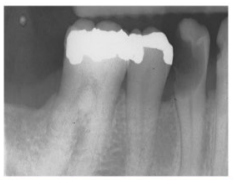


D3351

- Apexification
  - A benefit for permanent teeth under age 21
  - Initial visit – D3351
  - Requires
    - Prior authorization
    - PA radiograph
  - After D3351 completed member is eligible for D3352 once on a claim

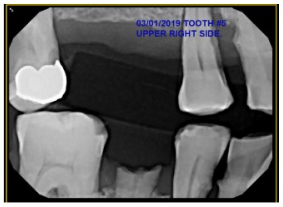
ARC 271F

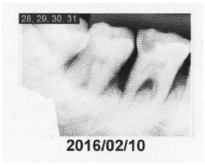
- Gross destruction of crown or root

ARC 271A

- Bone loss, mobility, periodontal pathology





Periodontics

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D4341 – D4342

- Scaling and Root Planing
  - A benefit once per quadrant every 24 months
  - Requires
    - Prior authorization
    - Periapical radiographs of all involved teeth in the requested quadrant and bitewings
    - Quadrant code
  - Periodontal chart/definitive periodontal diagnosis not required

D4341 – D4342

- Procedure D4341 a benefit when at least four teeth in the quadrant qualify for treatment
- Procedure D4342 a benefit when one, two, or three teeth in the quadrant qualify for treatment

D4341 – D4342

- For pregnant/postpartum members, scaling and root planing can be submitted on a TAR or a claim
- Indicate “pregnant” or “postpartum”
- Requires
  - Periapical radiographs of involved teeth (bitewings can be waived)
  - Quadrant code

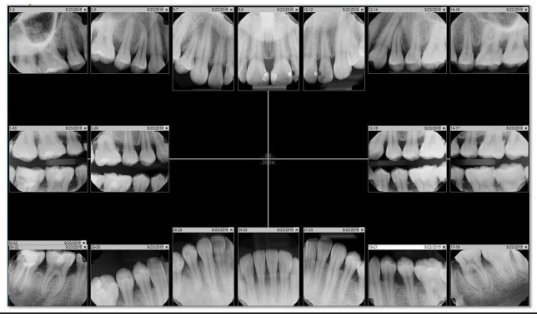
D4341 – D4342

- Only teeth that qualify as diseased are considered in the count for the number of teeth to be treated in a particular quadrant
- Teeth will not be counted as qualifying when they are indicated for extraction

D4341 – D4342

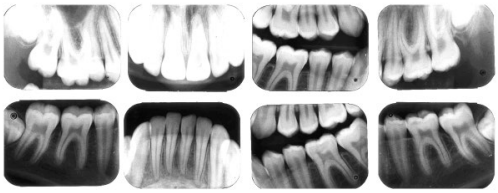
- Each qualifying tooth must show radiographic evidence of
  - Significant amount of bone loss or presence of calculus deposits (on root surfaces)
  - Restorability
  - Arch integrity

D4341 – D4342

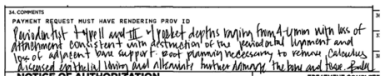


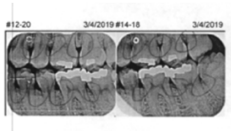
ARC 081

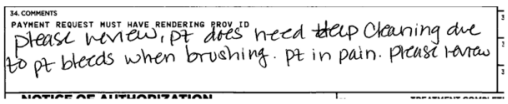
- Procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidence by the submitted radiographs



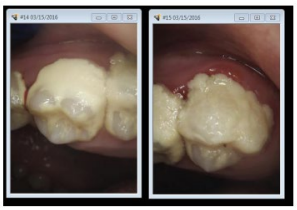
D4341 – D4342

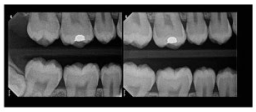






D4341 – D4342





- ARC 081

D4341 – D4342

- Prophylaxis not a benefit on the same date of service as scaling and root planing

D4346

- This procedure is considered included in the fee for another procedure and is not payable separately
- A procedure that is included in a global procedure cannot be billed to the member under any circumstances

D4910

- Periodontal Maintenance
  - A benefit for all members
  - A full-mouth treatment
  - Does not require prior authorization, periodontal charting, or radiographs

D4910

- Example of one calendar quarter:

D4910

- A benefit
  - Only when preceded by periodontal scaling and root planing
  - Only after completing all necessary scaling and root planing
  - Only in the 24-month period following the last paid scaling and root planing
  - Once per calendar quarter
- Not a benefit in the same calendar quarter as scaling and root planing, nor in the same calendar quarter as prophylaxis by the same provider

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Removable Prosthodontics

Removable Prosthodontics

- Effective January 1, 2018, all removable appliances and associated adjustments, repairs, and relines are now a benefit for all members

Removable Prosthodontics

Complete Dentures	Resin-Based RPDs	Cast RPDs
D5110 D5120	D5211 D5212	D5213 D5214

Each of these procedure codes requires:

- Prior authorization
- Radiographs of all remaining teeth in both arches
- A properly completed DC 054 form

Removable Prosthodontics

- Immediate Dentures D5130, D5140 do **not** require
  - prior authorization
  - radiographs
  - DC 054 form

Removable Prosthodontics

- Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR

Removable Prosthodontics

- Precision attachments and other specialized techniques are included in the fee for the appliance
- The fee includes all adjustments for 6 months
- Relines are a benefit after 6 months if the case involved extractions, and 12 months if did not

Removable Prosthodontics

- A benefit only once in a five-year period
- Authorization for replacement can be considered when existing prosthesis cannot be made serviceable by repair, replacement of broken/missing teeth, or reline
- Use the date prosthesis sent to lab for acrylic processing as the date of service
- Prosthesis must be delivered and in use by member before submitting for payment

Removable Prosthodontics

- Undeliverable denture payable at 80%
  - Indicate reason for non-delivery
  - Box 44 – date prosthesis ordered from lab
  - Submit NOA with lab invoice indicating prosthesis was processed in acrylic
  - Keep prosthesis in office in a deliverable condition for one year

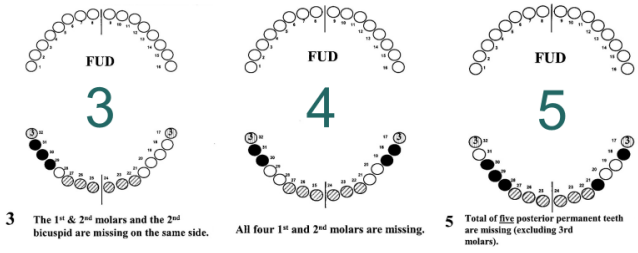
D5211 – D5212

- Resin base RPDs
  - A benefit when replacing a permanent anterior tooth/teeth, **or**
  - the arch lacks posterior balanced occlusion
  - D5211 - D5212 do not need to oppose a complete denture to be a benefit of the Program

D5213 – D5214

- Cast metal framework RPDs
  - A benefit only when opposing a full denture and when the arch lacks posterior balanced occlusion

Lack of Posterior Balanced Occlusion



3 The 1st & 2nd molars and the 2nd bicuspid are missing on the same side.

All four 1st and 2nd molars are missing.

5 Total of five posterior permanent teeth are missing (excluding 3rd molars).

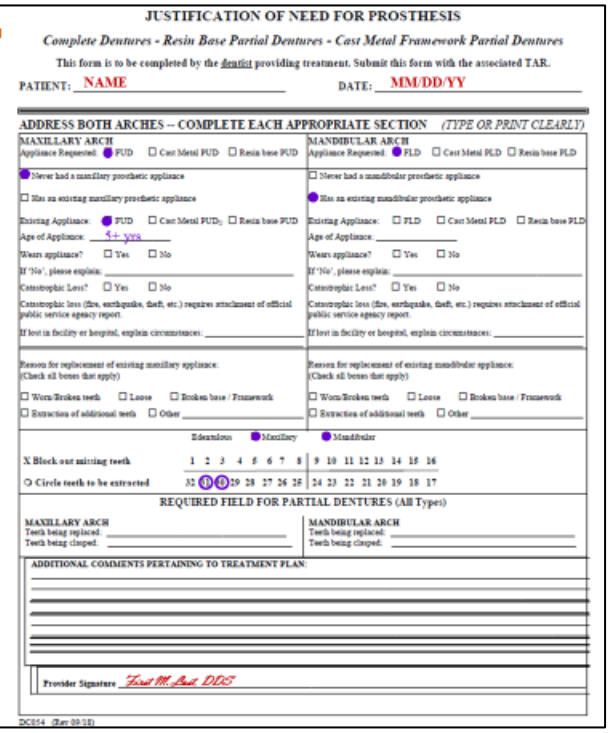
DC 054 Form

- Justification of Need for Prosthesis
- Submit current version of form (09/18)
- Requires
  - Member Name
  - Date DC 054 was completed
  - Provider signature

DC 054 Form

- Documentation must include:
- Both arches
- Missing teeth
- Teeth to be extracted
- Teeth being replaced by the requested partial prosthesis (excluding third molars)
- Teeth being clasped for partial dentures

- TAR requests complete upper denture



JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: NAME DATE: MM/DD/YY

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

MAXILLARY ARCH Appliance Requested: ● FUD ☐ Cast Metal FUD ☐ Resin base FUD	MANDIBULAR ARCH Appliance Requested: ● FLD ☐ Cast Metal FLD ☐ Resin base FLD
● Never had a maxillary prosthetic appliance	☐ Never had a mandibular prosthetic appliance
☐ Has an existing maxillary prosthetic appliance	● Has an existing mandibular prosthetic appliance
Existing Appliance: ● FUD ☐ Cast Metal FUD ☐ Resin base FUD	Existing Appliance: ☐ FLD ☐ Cast Metal FLD ☐ Resin base FLD
Age of Appliance: 5+ yrs	Age of Appliance:
Wears appliance? ☐ Yes ☐ No	Wears appliance? ☐ Yes ☐ No
If 'No', please explain:	If 'No', please explain:
Catastrophic Loss? ☐ Yes ☐ No	Catastrophic Loss? ☐ Yes ☐ No
Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.	Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.
If lost in facility or hospital, explain circumstances:	If lost in facility or hospital, explain circumstances:
Reason for replacement of existing maxillary appliance: (Check all boxes that apply)	Reason for replacement of existing mandibular appliance: (Check all boxes that apply)
☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework	☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework
☐ Extraction of additional teeth ☐ Other	☐ Extraction of additional teeth ☐ Other

Edentulous ● Maxillary ● Mandibular

X Block out missing teeth		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
○ Circle teeth to be extracted	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH	MANDIBULAR ARCH
Teeth being replaced:	Teeth being replaced:
Teeth being clasped:	Teeth being clasped:

ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:

Provider Signature: *Jane M. Last, DDS*

DC854 (Rev 09/18)

MAXILLARY ARCH
Appliance Requested: ■ FUD ☐ Cast Metal PUD ☐ Resin base PUD

■ Never had a maxillary prosthetic appliance

☐ Has an existing maxillary prosthetic appliance

Existing Appliance: ■ FUD ☐ Cast Metal PUD ☐ Resin base PUD

Age of Appliance: 5+ yrs

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Conflicting Documentation

This arch not addressed on TAR

MANDIBULAR ARCH
Appliance Requested: ■ FLD ☐ Cast Metal PLD ☐ Resin base PLD

☐ Never had a mandibular prosthetic appliance

■ Has an existing mandibular prosthetic appliance

Existing Appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD

Age of Appliance: _____

Wears appliance? ☐ Yes ■ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Conflicting Documentation

Edentulous ■ Maxillary ■ Mandibular

X Block out missing teeth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
❍ Circle teeth to be extracted	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- TAR could be denied with ARC 155 or 274
- ARC 155 – Procedure requires a properly completed DC 054 form
- ARC 274 – Comprehensive (full mouth) treatment plan is required for consideration of services requested

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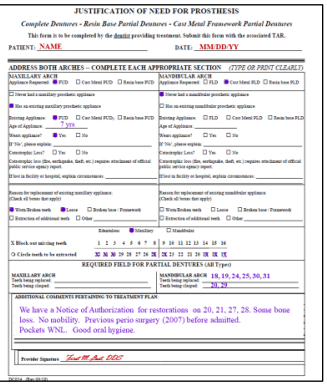
- TAR for D5110 and D5214

Complete Tx Plan

- Reason to replace
- Both arches addressed
- Perio condition
- Restorative
- Missing teeth
- Teeth to replace
- Teeth to clasp



JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: NAME DATE: MM/DD/YY

ADDRESS BOTH ARCHES – COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

MAXILLARY ARCH
Appliance Requested: ■ FUD ☐ Cast Metal PUD ☐ Resin base PUD

☐ Never had a maxillary prosthetic appliance

■ Has an existing maxillary prosthetic appliance

Existing Appliance: ■ FUD ☐ Cast Metal PUD; ☐ Resin base PUD

Age of Appliance: 7 yrs

Wears appliance? ■ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing maxillary appliance. (Check all boxes that apply)

■ Worn/Broken teeth ■ Loose ☐ Broken base / Framework

☐ Extraction of additional teeth ☐ Other _____

MANDIBULAR ARCH
Appliance Requested: ☐ FLD ■ Cast Metal PLD ☐ Resin base PLD

☐ Never had a mandibular prosthetic appliance

■ Has an existing mandibular prosthetic appliance

Existing Appliance: ☐ FLD ■ Cast Metal PLD ☐ Resin base PLD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing mandibular appliance. (Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework

☐ Extraction of additional teeth ☐ Other _____

Edentulous ■ Maxillary ☐ Mandibular

X Block out missing teeth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
❍ Circle teeth to be extracted	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth being replaced: _____
Teeth being clasped: _____

MANDIBULAR ARCH
Teeth being replaced: 18, 19, 24, 25, 30, 31
Teeth being clasped: 20, 29

ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN

We have a Notice of Authorization for restorations on 20, 21, 27, 28. Some bone loss. No mobility. Previous perio surgery (2007) before admitted. Pockets WNL. Good oral hygiene.

Provider Signature: Test Mr. Ass. DDS

Denture and RPD Adjustments

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Not payable to same provider to 6 months after
  - Delivery of denture
  - Reline
  - Repair
  - Tissue Conditioning

Denture and RPD Repairs

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Do not require
  - Prior authorization
  - Radiographs
  - Documentation

Denture and RPD Repairs – CDT-19

Deleted

- D5510 – Repair broken complete denture base
- D5610 – Repair resin denture Base
- D5620 – Repair Cast Framework
- D5860 – Overdenture – complete, by report
- D5861 – Overdenture – partial, by report

- New Codes
- D5511 – Repair broken complete denture base, mandibular
- D5512 – Repair broken complete denture base, maxillary

Denture and RPD Repairs – CDT-19

Deleted
- D5610 – Repair resin denture Base

New Codes
- D5611 – Repair resin partial denture base, mandibular
- D5612 – Repair resin partial denture base, maxillary

Denture and RPD Repairs – CDT-19

Deleted
- D5620 – Repair cast framework

New Codes
- D5621 – Repair cast partial denture framework, mandibular
- D5622 – Repair cast partial denture framework, maxillary

Denture and RPD Repairs – CDT-19

Deleted
- D5860 – Overdenture – complete
- D5861 – Overdenture - partial

New Codes
- D5863 – Overdenture – complete maxillary
- D5865 – Overdenture – complete mandibular
- Partial overdentures D5864, D5866 not a benefit

Relines

- A benefit once per 12 months
- D5211 D5212 do not qualify for laboratory reline – only a chairside reline
- Do not require
  - Prior authorization
  - Radiographs
  - Documentation

D5850 – D5851

- Tissue Conditioning
- A benefit twice in a 36-month period (per prosthesis, not per provider) – Check Medi-Cal Dental Program history
- Allowable same date of service as insertion of immediate denture
- Does not require
  - Prior authorization
  - Radiographs
  - Documentation

DHCS | Medi-Cal Dental

Extractions

Extractions

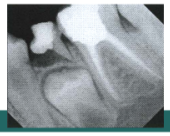
Procedure Code	Description
D7111	Coronal Remnant - deciduous tooth
D7140	Extraction of erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone or sectioning tooth
D7220	Impacted, soft tissue
D7230	Impacted, partial bony
D7240	Impacted, complete bony
D7241	Impacted, complete bony with surgical complications
D7250	Surgical removal of residual root (cutting procedure)

Extractions

- Fee includes
  - Local anesthesia
  - Sutures
  - Routine post-operative care within 30 days
- Extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars are a benefit

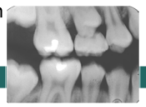
D7111

- Extraction, coronal remnants, deciduous tooth
- Documentation/radiographs not required
- Requires tooth number
- Not a benefit for asymptomatic teeth



D7140

- Extraction, erupted tooth or exposed root
- Radiographs not required
- Requires a tooth number
- Not a benefit
  - For asymptomatic teeth
  - For root removal by the same billing provider who performed the initial extraction
  - For primary teeth near exfoliation

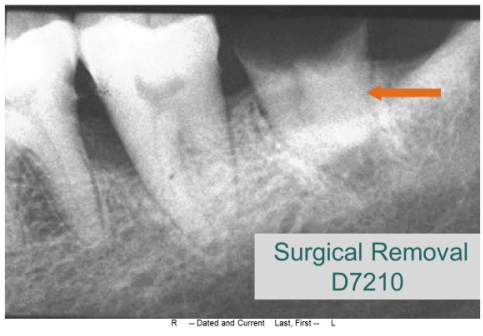


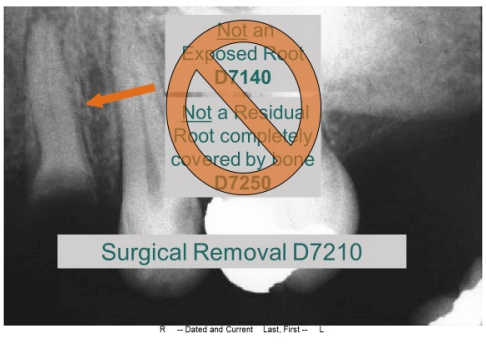
Radiographs for Extractions

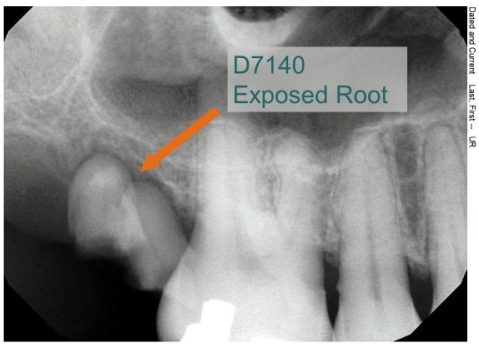
- No radiographs required for D7111 or D7140
- Radiographs required for
  - D7210
  - D7220
  - D7230
  - D7240
  - D7241
  - D7250
- Prior authorization not required for any extraction

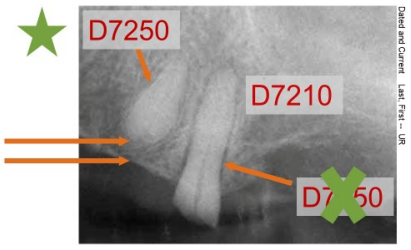
D7210

- Surgical Removal
  - A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth
  - Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal







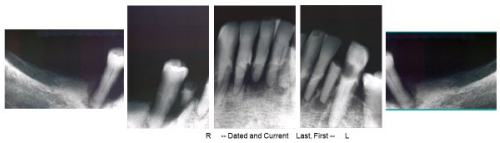


D7250 Surgical removal of residual tooth roots – Cutting procedure (Root completely covered by bone)

Radiographs vs. Documentation

34. COMMENTS
Crown undermined by decay prohibiting normal forceps technique on teeth # 13 and # 15 . Consent signed and post op instructions given .

Radiographs vs. Documentation



- "Surgical extractions, ankylosis, fused to bone, flap – surgical bur"

Third Molars

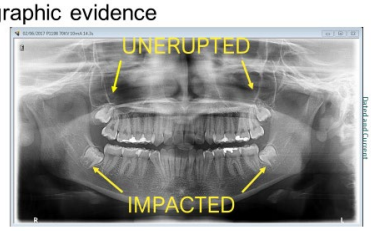
- Per Stedman's Medical Dictionary, 23rd Ed
- Unerupted tooth:
  - Denoting a tooth that has yet to pass through the alveolar process and perforate the gums
- Impacted tooth
  - Denoting a tooth so placed in the alveolus as to be incapable of eruption into normal position

Third Molars

- Document specific condition or medical necessity for each tooth identified for extraction
- Submit current radiograph depicting the entire tooth
- Prophylactic removal for some adverse condition that may or may not occur in the future is not a benefit

ARC 048

- Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence



D9930

- Treatment of complications (post-surgical) – unusual circumstances
  - A benefit within 30 days of extraction for
    - Dry socket
    - Excessive bleeding
    - Removal of bony fragment
    - Infection
    - Life-threatening allergy related to recent extraction
  - Requires Documentation
    - Use formula for emergency visit

Anesthesia

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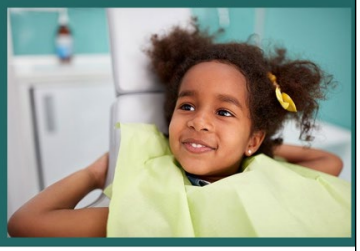

Anesthesia Procedures

- Deep Sedation/General Anesthesia – CDT 19 Codes
  - D9222 – first 15 minutes
  - D9223 – each additional15 minutes
- Analgesia, anxiolysis, inhalation of nitrous oxide (D9230)
- Intravenous conscious sedation/analgesia
  - D9239 – first 15 minutes
  - D9243 – each additional 15 minutes
- Non-intravenous conscious sedation (D9248)

Anesthesia Procedures

- General Policies:
- The administration of sedation and therapeutic drug injection D9610 is a benefit
  - In conjunction with payable associated procedures
  - Prior authorization or payment shall be denied if all associated procedures by the same provider are denied
- Only the most profound anesthesia paid

D9230

- Nitrous oxide
  - Does not require prior authorization
  - No documentation required for members under age 13
  - Age 13 or older
    - Documentation is required that indicates physical, behavioral, developmental or emotional condition that prohibits the member from adequately responding to provider's attempt to perform treatment

D9248

- Non-intravenous conscious sedation
  - Does not require prior authorization
  - Requires written documentation
    - Under age 13 – agent and method of administration
    - Age 13 or older – agent, method of administration, and medical necessity

D9248

- Acceptable agents include, but are not limited to, Demerol, chloral hydrate, fentanyl, ketamine, Nembutal, valium, versed, Vistaril, etc.
- Acceptable methods of administration
  - Oral
  - Patch
  - Intramuscular
  - Subcutaneous
- A benefit once per date of service per provider

Anesthesia Procedures

- Provider who render D9222 or D9239 shall have valid anesthesia permits with the California Dental Board, and must have their permit on file with the Medi-Cal Dental Program
- Providers rendering D9222 or D9239 on Medi-Cal Dental Program members must be enrolled in the Program

Anesthesia Procedures

- D9222 and D9239 require prior authorization
- With NOA, a signed anesthesia record is required that indicates
  - Anesthetic agent – induction agent must be documented
  - Length of anesthesia (start and stop time), not including prep or recovery time

D9920

- Behavior Management, By Report
  - Cannot be prior authorized
  - Requires documentation
    - Member must be a special needs individual – include medical diagnosis
    - Document reason for the need of additional time for a dental visit
  - A benefit for four visits in a 12-month period
  - Only in conjunction with procedures that are payable

D9920

- Three new ARCs introduced in Bulletin Volume 35 Number 14
- 071A – Not payable when sedation is used as a behavior modification modality
- 071B – only payable when the member is a special needs member that requires additional time for a dental visit
- 071C – Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit
- https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_14.pdf

Case Management

- Designed for members with special health care needs who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers.

Case Management

- Examples of special health care needs include
  - Physical
  - Developmental
  - Mental
  - Sensory
  - Behavioral
  - Cognitive or emotional impairment
  - Or some limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs

Case Management

- Referrals for Case Management Services are initiated by:
  - The member's Medi-Cal Dental provider and based on a current, comprehensive evaluation and treatment plan
  - Medical provider or other healthcare professional
  - Social Worker
- Case Management referral form is located on the Medi-Cal Dental website
  - Referrals are to be emailed
  - Referral forms are not accepted by mail

EPSDT

- Early and Periodic Screening, Diagnostic, and Treatment Services
- In accordance with the Social Security Act and federal regulations, DHCS must provide full-scope Medi-Cal members under age 21 with a comprehensive, high-quality array of preventive, diagnostic, and treatment services under EPSDT

EPSDT

- EPSDT services might or might not be part of the Manual of Criteria
- A service is medically necessary if it corrects or ameliorates defects and physical and mental illnesses or conditions

EPSDT

- A TAR is required when a procedure is not listed in the Manual of Criteria, or a service does not meet the published criteria for a procedure
  - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition

EPSDT Example

- Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive.
- With adequate documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT service.

EPSDT Example

- Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planing. The Manual of Criteria states this procedure is not a benefit for patients under 13 years of age. However, as a documented medically necessary periodontal procedure, it may be authorized as an EPSDT service when there is radiographic evidence of bone loss.

American Sign Language

Medi-Cal Dental reminds providers that American Sign Language (ASL) translation and language assistance services are available to Medi-Cal members at no cost.

- Provider or member can request language assistance by calling the Telephone Service Center (TSC)
- Language assistance over the telephone or to schedule an ASL translator to be present at the time of the appointment.
- Providers can supply a language interpreter in the office, or providers can call the TSC to access language interpreters available in 250 languages and dialects.
- Free language tagline signs are available:

https://smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

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Language Assistance Services

- Provider requesting translator for member should call:
  Telephone Service Center at (800) 423-0507
- Member requesting Translator should call:
  Telephone Service Center at 1-800-322-6384
- Members with hearing or speaking limitations can call:
  Teletext Typewriter (TTY) line at (800) 735-2922

(Monday through Friday, 8 a.m. to 5 p.m. at all other times, Medi-Cal members should call the California Relay Service TDD/TTY at 711 to receive the help they need.)

Refer to bulletin Volume 35, Number 12, in the bulletin section of the Medi-Cal Dental website.

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Phone Numbers and Websites

Provider Toll-Free Line (Medi-Cal Dental)	800-423-0507
Member Toll-Free Line (Medi-Cal Dental)	800-322-6384
A.E.V.S. (to verify eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S./Internet Help Desk	800-541-5555
Medi-Cal Website (to verify member eligibility)	www.medi-cal.ca.gov
Medi-Cal Dental Website	www.dental.dhcs.ca.gov
EDI Technical Support	916-853-7373
Medi-Cal Dental Forms (fax number)	877-401-7534
Health Care Options	800-430-4263

CA Department of Public Health

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx

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ADJUDICATION REASON CODES

DIAGNOSTIC/PREVENTIVE	
001	Procedure is a benefit once per patient, per provider.
001A	An orthodontic evaluation is a benefit only once per patient, per provider.
002	Procedure is a benefit once in a six-month period for patients under age 21.
002A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for patients under age 21.
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.
004A	Procedure D1320 is only a benefit when billed on the same date of service as procedure D0150 or D0120 to the same provider.
006	Procedure is a benefit once per tooth.
008	Procedure was not adequately documented.
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.
010	Procedure 020 not a benefit in conjunction with Procedure 030.
011	Procedure 030 is payable only once for a visit to a single facility or other address per day regardless of the number of patients seen.
011A	Procedure 030 is payable only when other specific services are rendered same date of service.
012	Procedure 030, time of day, must be indicated for office visit.
012A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030
013	Procedure requires an operative report or anesthesia record with the actual time indicated.
013A	Procedure has been authorized. However, the actual fee allowance cannot be established until payment is requested with the hospital time documented in operating room report.
013B	Procedure D9410 is not payable when the treatment is performed in the provider's office or provider owned ambulatory surgical center.
013C	The anesthesia record must be signed by the rendering provider and the rendering provider's name and permit number must be printed and legible.
013D	The treating provider name on the anesthesia record does not coincide with the Rendering Provider Number (NPI) in field 33 on the claim.
013E	The treating provider performing the analgesia procedure must have a valid permit from the DBC and the permit number must be on file with Denti-Cal.

014	Procedure is not a benefit to an assistant surgeon.
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
020A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
020B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
020C	Prophy and fluoride procedures are allowable once in a six month period.
020D	Prophy and fluoride procedures are allowable once in a 12 month period.
020E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
020F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
020G	Topical application of fluoride is payable only for caries control.
020I	Patients under age 6, fluoride procedures are allowable once in a 4-month period and prophy procedures are allowable once in a 6-month period.
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.
022	Full mouth or panographic X-rays are a benefit once in a three year period.
023	A benefit twice in a six-month period per provider.
024	A benefit once in a 12-month period per provider.
024A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
024B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
024C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
024D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.
024E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
024F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.
027	Procedure is not a benefit for edentulous areas.
028	A benefit once in a six-month period per provider.
028A	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
028B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
029	Payment/Authorization denied due to multiple unmounted radiographs.
029A	Payment/Authorization denied due to undated radiographs or photographs.

029B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.
029C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.
029D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.
029E	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative
029F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.
029G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
029H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.
030	An adjustment has been made for the maximum allowable radiographs.
030A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
030B	Combination of radiographs is equal to a complete series.
030C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.
030D	Periapicals are limited to 20 in any consecutive 12-month period.
031	Procedure is payable only when submitted.
031A	Photographs are a benefit only when appropriate and necessary to document associated treatment.
031B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.
031C	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
031D	Photographs are not payable when the date does not match the date of service on the claim.
032A	Endodontic treatment and postoperative radiographs are not a benefit.
032B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
032C	X-rays disallowed for the following reasons: X-rays appear to be of another person.
032D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.
033A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
034	Emergency procedure cannot be prior authorized.
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
038	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free
039	Dental sealants are only payable when the occlusal surface is included.
039A	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
	ORAL SURGERY
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
043A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedure(s).

044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
046A	Post-operative visits are not payable after 30 days following the surgical procedure.
047	Post operative care within 90 days by the same provider is not payable.
047A	Post operative care within 30 days by the same provider is not payable.
047B	Post operative care within 24 months by the same provider is not payable.
048	Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
049	Extractions are not payable for deciduous teeth near exfoliation.
050	Surgical extraction procedure has been modified to conform with radiographic appearance.
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
054A	Procedure is not a benefit within six months of extractions in the same quadrant.
054B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.
058	Procedure is a benefit for anterior permanent teeth only.
059	Procedure allowed per Current Procedural Terminology (CPT) code description.
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
	DRUGS
063	Only the most profound level of anesthesia is payable per date of service. This procedure is considered global and is included in the fee for the allowed anesthesia procedure.
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.
066	The need for 301 must be justified and documented.
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.
069	Procedure is not a benefit when all additional services are denied or when there are no additional services submitted for the same date of service.
070	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.

071	Intravenous Sedation or General Anesthesia is not deemed medically necessary based on the treatment plan and/or documentation submitted. Please submit additional documentation to justify the medical necessity for IV Sedation/GA or attempt treatment under a less profound sedation modality.
071A	Behavior Modification (D9920) is not payable when sedation is used as a behavior modification modality.
071B	Behavior Modification (D9920) is only payable when the patient is a special needs patient that requires additional time for a dental visit.
071C	Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit.
	PERIODONTICS
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.
073	Periodontal chart not current.
073A	Periodontal chart not current. Older than 14 months.
073B	Periodontal chart not current. Periodontal treatment performed after charting date.
073C	Periodontal chart not current. Charting date missing or illegible.
073D	Periodontal chart not current. Charting date invalid or dated in the future.
073E	Periodontal chart not current. Older than 12 months
074A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.
074B	Periodontal procedure disallowed due to inadequate charting of: Mobility.
074C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.
074D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.
076	A benefit twice in a 12-month period per provider.
077	Periodontal procedures 452, 472, 473, and 474 are not benefits for beneficiaries under 18 years of age except for cases of drug-induced hyperplasia.
077A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.
079	Multiples of Procedure 452 must be performed on different days.
080	A prophy or prophy and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.
081	Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs.
081A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.
083A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.
085A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.

085B	Only one Scaling and Root Planing, or Perio Maintenance or Prophylaxis procedure is allowable within the same calendar quarter.
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
086A	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
087A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
087B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.
088	Procedure is a benefit once per quadrant every 24 months.
088A	Procedure is a benefit once per quadrant every 36 months.
089	Procedure is not a benefit for periodontal grafting.
	ENDODONTICS
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
091A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.
092	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary post operative care within 90 days.
093A	Endodontic procedure is not payable when root canal filling underfilled.
093B	Endodontic procedure is not payable when root canal filling overfilled.
093C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.
093D	Endodontic procedure is not payable when: Root canal filling is undercondensed.
093E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
093F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
096	Procedure not a benefit in conjunction with a full denture or overdenture.
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
098	Procedures 530 and 531 include retrograde filling.
099	A benefit once per tooth in a six-month period per provider.
100	Procedure is not a benefit for an endodontically treated tooth.
101	This procedure requires a prerequisite procedure.
101A	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.

RESTORATIVE	
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
113A	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
113B	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
113C	Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.
113E	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
113F	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a pre-fabricated or laboratory processed crown and the need for the restoration is not justified.
114	Tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures are included in the fee for a completed restorative service.
115	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
116	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspids.
117	Procedure not a benefit for a primary tooth near exfoliation.
118	Proximal restorations in anterior teeth are paid as single surface restorations.
119	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
120	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
121	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
121A	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
122	Tooth does not meet the Manual of Criteria for a prefabricated crown.
123	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
124	Radiograph or photograph indicate additional surface(s) require treatment.
124A	Decay not evident on requested surface(s), but decay evident on other surface(s).
125	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.
125A	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.

125B	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
126	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.
127	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
128	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
131	Procedure is a benefit only in cases of extensive coronal destruction.
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
133	Procedure not allowed due to denial of a root canal filled with silver points.
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed; i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
136	Procedure not a benefit for prefabricated crowns.
	PROSTHODONTICS
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
146	A removable partial denture includes all necessary clasps, rests and teeth.
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
148	Sufficient teeth are present for the balance of the opposing prosthesis.
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
149A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
151	This procedure is not a benefit for a resin base partial denture.
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).

153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.
155	Procedure requires a properly completed prosthetic DC054 form.
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.
157	A laboratory invoice is required for payment.
160	Laboratory or chairside relines are a benefit once in a 12 month period per arch.
161	Procedure 722 is a benefit once in a 12-month period per arch.
161A	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.
161B	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.
162	Patient's existing prosthesis is adequate at this time.
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).
164	Prosthesis serviceable by laboratory reline.
165	Existing prosthesis can be made serviceable by denture duplication ("jump", "reconstruction").
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
168A	Patient does not wish extractions or any other dental services at this time.
168B	Patient has selected different provider for treatment.
169	Procedure 723 is limited to two per appliance in a full 12 month period.
169A	Procedure is limited to two per prosthesis in a 36-month period.
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.
172	Payment for a prosthesis is made upon insertion of that prosthesis.
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five year period.
174	Procedure 724 is a benefit only when the existing denture is at least two years old.
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.
175A	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.
176	Per radiographs, insufficient tooth space present for the requested procedure.
177	New prosthesis cannot be authorized. Patient's dental history shows prosthesis made in recent years has been unsatisfactory for reasons that are not remediable.
178	The procedure submitted is no longer a benefit under the current criteria manual. The procedure allowed is the equivalent to that submitted under the current Schedule of Maximum Allowances and criteria manual.
179	Procedure requires prior authorization and cannot be considered as an emergency condition.
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.
	SPACE MAINTAINERS
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.

194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.
195	A space maintainer is not a benefit for the upper or lower anterior region.
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.
197	Procedure requested is not a benefit when only one tooth space is involved or qualifies. Maximum benefit has been allowed.
197A	Procedure is only a benefit to maintain the space of a single primary molar.
	ORTHODONTIC SERVICES
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200A	Adjustments of banding and/or appliances are allowable once per quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
	MAXILLOFACIAL SERVICES
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12 month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.

222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon's provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: "CCS approved" stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.

MISCELLANEOUS	
258	Functional limitations or health condition of the patient preclude(s) requested procedure.
259A	Procedure not a benefit within 6 months to the same provider.
259B	Procedure not a benefit within 12 months to the same provider.
259C	Procedure not a benefit within 36 months to the same provider.
259D	Procedure not a benefit within 24 months to the same provider.
259E	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
260	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
261	Procedure is not a benefit of this program.
261A	Procedure code is missing or is not a valid code.
261B	CDT codes are not valid for this date of service.
261C	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
262	Procedure requested is not a benefit for children.
263	Procedure requested is not a benefit for adults.
264	Procedure requested is not a benefit for primary teeth.
265	Procedure requested is not a benefit for permanent teeth.
266A	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
266B	Payment and/or prior authorization disallowed. Lack of radiographs.
266C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
266D	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
266E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
266F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
266G	Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.
266H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.
266I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
266J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
266K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
266L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
266M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
266N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
267	Documentation not submitted.
267A	Description of service, procedure code and/or documentation are in conflict with each other.
267B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.
267C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.

267D	Documentation insufficient/not submitted. Study models not submitted.
267E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.
267F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
267G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
267H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
267I	Documentation submitted is incomplete.
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
268A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.
268B	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
268C	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate fo a FRADS that may be a covered benefit.
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
269B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
269C	Procedure denied for the following reason: Associated with another denied procedure.
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
271A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
271B	Procedure is disallowed due to the following: Apical radiolucency.
271C	Procedure is disallowed due to the following: Arch lacks integrity.
271D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
271E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
271F	Procedure is disallowed due to the following: Gross destruction of crown or root.
271G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.
271H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
271I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
271J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.
272	Tooth not present on radiograph.
272A	Per radiograph, tooth is unerupted.
272B	Radiographs and/or documentation reveals that tooth number may be incorrect.
273	Procedure denied as beneficiary is returning to original provider.
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.

274A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
274B	Authorized treatment plan has been altered; therefore, payment is disallowed.
274C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
274D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
278	Preventive control programs are included in the global fee.
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
280	Not payable when condition is asymptomatic.
281	Services solely for esthetic purposes are not benefits.
282	By-report procedure documentation missing or insufficient for payment calculations.
283	Payment amount determined from documentation submitted for this by-report procedure.
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.
284A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
284B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.
284C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
284D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
284E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.
285	Procedure does not show evidence of a reasonable period of longevity.
285A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
286	Procedure previously rendered.
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
287A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.
288	Procedure cannot be considered an emergency.
289	Procedure requires prior authorization.
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
291	Per date of service, procedure was completed prior to date of authorization.
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.

293A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
293C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.
294A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
297	Procedure 803 not covered as a separate item. Global fee where a benefit.
298	A fee for completion of forms is not a covered benefit.
299	Complete denture procedures have been rendered/authorized for the same arch.
299A	Extraction procedure has been rendered/authorized for the same tooth.
300	Procedure recently authorized to your office.
300A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.
303A	Fixed Partial Dentures are not a benefit when the number of missing teeth in the posterior quadrant(s) do not significantly impact the patient's masticatory ability.
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.
305	Procedure not a benefit for tooth/arch/quad indicated.
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.
307A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.
307B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.
308	Procedure disallowed due to a beneficiary identification conflict.
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.
	PAYMENT POLICY
312	Certified orthodontist not associated to this service office.
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.
313A	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No other coverage EOB/RA, fee schedule or proof of denial submitted.

313B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
313C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
313D	Study models submitted are non-diagnostic, untrimmed, or broken.
313E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.
314A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
314B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
314C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.
314D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
314E	Per radiographs or documentation, please re-evaluate for: Procedure 706
314F	Per radiographs or documentation, please re-evaluate for: Procedure 708
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.
316	Payment disallowed. Request received over 12 months from end of month service was performed.
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).
317A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
317B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).
318	Recipient eligibility not established for dates of services.
318A	Recipient eligibility not established for dates of services. Share of cost unmet.
319	Rendering or billing provider NPI/ID not on file.
319A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.
320	Rendering or billing provider not enrolled for date of service.
320A	Rendering or billing provider is not enrolled as a certified orthodontist.
320B	The billing provider has discontinued practicing at this office location for these Dates of Service.
320C	Rendering provider must be CRA certified and opt-in.
321	Recipient benefits do not include dental services.
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.
326	Procedures being denied on this document due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document.
326A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.
327	Payment cannot be made; our records indicate patient deceased.

328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.
330A	Beneficiary is not eligible for Medi-Cal dental benefits. Verify beneficiary's enrollment in Healthy Families which may include dental benefits.
331	Authorized services are not a benefit if patient becomes ineligible during authorized period and services are performed after the patient has reached age 18 without continuing eligibility.
332	Share of cost patient must pay for these services.
333	Payment cannot be made for procedures with dates of service after receipt date.
333A	Payment disallowed. Date of service is after receipt date of first NOA page(s).
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.
335	Billing provider name does not match our files; payment/ authorization cannot be made.
336	Beneficiary is not eligible for dental benefits.
337	The procedure is not a benefit for the age of the beneficiary.
337A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.
338	This service will be processed under the former contract separately.
339	The POE label on the claim appears to be altered. Please contact the recipient's county welfare office to validate eligibility. Resubmit the claim with a valid label.
340	This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a Claim Inquiry Form (CIF). The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim.
341	This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a Claim Inquiry Form (CIF). This denied, duplicate procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)
342	Rendering provider required for procedure, none submitted.
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
345	Payment cannot be made for procedures with invalid dates of service.
345A	The PM 160 form sent was not current. Send claim inquiry form with current PM 160 form or document reason for delay in treatment.
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.
347	Authorization previously denied, payment cannot be made.
348	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service already performed on the same day by the same DDS.
348A	The billed procedure cannot be paid because there is an apparent discrepancy between it and procedure D0220 already performed on the same day. If you are requesting re-adjudication for this procedure, submit a Claim Inquiry Form (CIF).

349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.
350	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided for this patient.
351	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided by your office for this patient.
352	The billed service is disallowed because of an apparent discrepancy with a related procedure billed by your office for the same tooth on the same day.
352a	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
353	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
354	The line item is a duplicate of a previous line item on the same claim.
355A	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355B	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355C	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
356	EOMB for different recipient, procedure(s) denied.
357	Procedure deleted/disallowed per provider request.
358	Payment for procedure disallowed per claims review.
359	Payment for procedure disallowed per clinical post-payment review.
360	Sign Notice of Authorization for payment of dated lines.
361	CSL has not been paid; NOA never returned for payment.
362	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
363	Procedure on EOMB is not a benefit of the program.
364	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
365	The maximum allowance for this service/procedure has been paid by Medicare.
366	Dental benefits cannot be paid without proof of payment/denial from Medicare.
367	Medicare payment/denial notice does not have recipient name and/or date of service.
368	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
369	Emergency certification statement is insufficient /not submitted for recipient aid code.
369A	Provider must sign the emergency certification statement.
370	Procedure not a benefit for recipient aid code.
370A	Per box "D" marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
371	Procedure(s) cannot be prior authorized for recipient aid code.
372	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
373	Procedure not payable. CTP benefits terminate at age 19.
374	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.

376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.
377	This procedure is not a benefit for an RDHAP/RDHEF/RDH.
377A	Procedure requested is only payable when the patient resides in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF) that is licensed pursuant to Health And Safety Code (H&S Code) Section 1250-1264.
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
380	Fee adjustment, since Other Coverage exists for this claim.
381	Fee adjustment, since Third Party Liability exists for this claim.
382	Fee adjustment, since share of cost exists for this claim.
383	Fee adjustment, since services billed were not provided.
384	Fee adjustment, due to findings of professional peer review.
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).
386A	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).
387A	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
392	Beneficiary is not eligible for CCS/GHPP benefits.
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.
400	EPSDT services are not a benefit for patients 21 years and older.
401	The EPSDT service requested is primarily cosmetic in nature and not medically necessary per EPSDT criteria.
402	An alternative service is more cost effective than the requested EPSDT service and is a benefit of the Medi-Cal dental program. Please re-evaluate.
403	The EPSDT service requested is not medically necessary.
403A	Procedure has been allowed under EPSDT criteria.
403B	Procedure code was allowed under EPSDT criteria. In addition, procedure code also qualifies for Proposition 56: Tobacco Tax Funds Supplemental payment of the current SMA for dates of service 07/01/2017-12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook Section 4-Treating Beneficiaries.
404	Procedure is disallowed due to presumptive eligibility card not submitted.

405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.
437	CRA procedure code must be performed in a DTI domain 2 county.
437A	CRA procedure code must have the same dates of service and be billed on the same claim.
438A	CRA procedure code is allowable once every 6 months for low risk patients.
438B	Procedure D1354 is allowable once every 6 months when CRA includes high risk procedure D0603.
438C	CRA procedure code is allowable once every 4 months for moderate risk patients.
438D	CRA procedure code is allowable once every 3 months for high risk patients.
438E	Additional services are allowable in conjunction with CRA procedure codes.
439	Payment denied due to lack of DTI domain 2 Funding.
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.
501	Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.
503A	Optional Adult Dental procedure is not a benefit
503B	Optional Adult Dental procedure is not a benefit
505	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA for dates of service 07/01/2017 - 12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook: Section 4-Treating Beneficiaries.* *Effective December 26, 2018.
505A	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA for dates of service 07/01/2017 - 12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook: Section 4-Treating Beneficiaries. Additional services are allowable in conjunction with CRA procedure codes.* *Effective December 26, 2018.
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.
555B	Authorization of this line is no longer valid: Treatment was performed as an emergency.
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed.
777	A special exception has been made for this procedure based on the documentation submitted.
888	Line allowed but unpaid due to date of service
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.
	CLINICAL SCREENING CODES
603	Per clinical examination, procedure requested is only allowable under special circumstances.
607A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.
607B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
613A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.

613B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
614A	Per clinical screening, please re-evaluate for: Complete upper denture
614B	Per clinical screening, please re-evaluate for: Complete lower denture
614C	Per clinical screening, please re-evaluate for: Resin base partial denture
614D	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
614E	Per clinical examination, please re-evaluate for: Procedure 706.
614F	Per clinical examination, please re-evaluate for: Procedure 708.
619	Per clinical screening, caries not clinically verified.
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
648	Per clinical screeneing, extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
649A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
662	Per clinical screening, existing prosthesis is adequate at this time.
662A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
667A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.
668	Per clinical screening, the need for procedure is not medically necessary.

668A	Per clinical screening, patient does not wish extractions or any other dental services at this time.
668B	Per clinical screening, patient has selected/wishes to select a different provider.
669A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.
669B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
669C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.
671A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
671B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
671C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
671D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
671E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.
671F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
671G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.
671H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
671I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.
672	Per clinical screening, tooth not present.
672B	Per clinical screening and/or radiographs, tooth number may be incorrect.
673A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
674	Per clinical screening, incomplete treatment plan submitted.
674A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
674C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
680	Per clinical screening, services solely for esthetic purposes are not benefits.
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.
684A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.
684B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.

684C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.
684D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
684E	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Two or more of the above pertain to your case.
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.
685A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
687	Per clinical screening, allowance made for alternate procedure.
692	Per clinical screening, documentation or radiographs, procedure already completed.
693	Per clinical screening, procedure requested is inadequate to correct problem.
693A	Per clinical screening, procedure requested is inadequate to correct problem. Tooth has open, underformed apices. Authorization for root canal will be considered after radiographic evidence of apex closure following apexification.
693B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.
693C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.
694A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.
695	Authorization disallowed as the patient is no longer at the facility.
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.

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