Safety Net Clinic Dental Policy Clarification Training

Medi-Cal Dental

September 2024

Agenda

Overview of Medi-Cal Dental Policies:

- Key References
- Eligible Members
- Billable Providers
- Billable Services

Department of Health Care Services (DHCS)

- The mission of DHCS is to provide Californians with access to affordable, high-quality health care, including:
  - Medical
  - Dental
  - Mental health
  - Substance Use Treatment Services
  - Long-term care

KEY REFERENCES

Key References

- Medi-Cal Dental Program Provider Handbook
  - Section 4 - Treating Members
  - Section 5 - Manual of Criteria (MOC)
  - Section 8 - Fraud, Abuse, and Quality of Care
  - Section 9 – Special Programs
- Medi-Cal Dental Provider Bulletins
  - Note: Providers may subscribe to receive bulletin notifications here
- California Code of Regulations (CCR) Section 51506. Dental Services

Key References

- Indian Health Services Memorandum of Agreement 638 Clinics (IHS/MOA) Manual
- Workbook_Medi-Cal Provider Training 2022: FQHC, RHC, Tribal FQHC & IHS-MOA Services (fqhc_2022)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs:
  - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural) (ca.gov)
  - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes (rural cd) (ca.gov)
- Tribal Federally Qualified Health Centers (Tribal FQHCs):
  - Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes (tribal fqhc cd) (ca.gov)
  - Tribal Federally Qualified Health Centers (Tribal FQHCs) (tribal fqhc) (ca.gov)

Medi-Cal Training Courses for Dental Providers

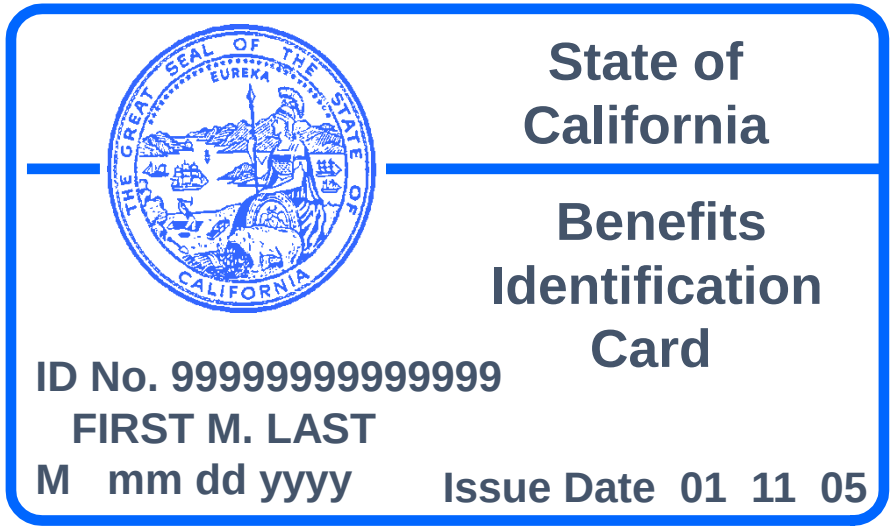
- Medi-Cal Dental Provider Training includes:
  - Basic and EDI Seminars/Webinars
  - Advanced Seminars/Webinars
  - Ortho Seminars/Webinars
  - Workshops
  - On-demand training videos
- Medi-Cal Dental training courses provide Continuing Education (CE) credits

ELIGIBLE MEMBERS

Member Eligibility

- Eligibility is established by the County Department of Social Services
  - Information is transferred to DHCS
  - Benefits Identification Card is issued
- Providers must verify eligibility monthly for each member who presents their Member ID Number (BIC)
- Eligibility Verification Confirmation (EVC) Number

Medi-Cal Benefits Identification Card (BIC)



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Verifying Member Eligibility

- There are two ways to verify eligibility through the Point of Service (POS) Network:
- By touch-tone telephone 800-456-2387
  - Automated Eligibility Verification System (AEVS)
  - Then enter the assigned 6-digit PIN
- By internet access www.medi-cal.ca.gov
  - Enter the billing provider number and 6-digit PIN
  - Place printout in the member record
  - Access Request a POS Network/Internet Agreement
- Request a POS Network/Internet Agreement from the POS/Internet Helpdesk 1 (800)541-5555 or access on the Medi-Cal website.

Member's Scope of Benefits

- Full Scope Medi-Cal includes, but is not limited to:
  - Medical
  - Dental
  - Mental Health Services
- Restricted/Limited Scope Medi-Cal includes limited health services depending on member eligibility:
  - Emergency-only services
  - Pregnancy
  - Postpartum

BILLABLE PROVIDERS

Billable Providers

- Dentists
- Registered Dental Hygienists (RDHs) and Registered Dental Hygienists in Alternative Practice (RDHAPs)
- Qualified Orthodontists
- Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEFs) **are not billable providers** under any circumstances

  Welfare & Institutions Code, Section 14132.100(g)(1)
  Welfare & Institutions Code, Section 14132.100(g)(2)(A)
  Title 22, Section 51223(c)

- For IHS Clinics: Business and Professions Code, Section 719(a)(b)

Enrollment

- Safety Net Clinics (SNC) do not need to enroll in Medi-Cal Dental separately
- Rendering Providers who are not enrolled in Medi-Cal Dental who order, refer or prescribe, must enroll as a Medi-Cal dental provider by visiting: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

Provider Application for Validation and Enrollment (PAVE)

- PAVE Application: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx
- For assistance with the application process, practitioners may:
  - Contact the Provider Enrollment Division (PED) by visiting the PED web page https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
  - Select the Inquiry Form link under "Provider Resources" for the PED Online Inquiry Form
- For PAVE technical support,
  - The PAVE Help Desk is available Monday through Friday from 8:00am to 6:00pm (excluding State holidays) at (866) 252-1949
  - The PAVE Chat feature is available Monday through Friday from 8:00am to 4:00pm (excluding State holidays)

Contracts with Private Dental Providers

- All dental service claims billed by an SNC and reimbursed by Medi-Cal that are rendered pursuant to a contract between the clinic and a private practice, the dental provider must adhere to:
  - Medi-Cal Dental Handbook
  - Applicable Legal Requirements
    - Enrollment
    - Documentation
    - Treatment Plan

Registered Dental Hygienist Billing

- A Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) can bill for RDH services rendered to a Medi-Cal member, after an approved adjustment to its per-visit rate.
- An FQHC/RHC may not bill for RDH services until it obtains an approved adjustment to its per-visit rate.
- An FQHC/RHC that doesn't provide dental hygienist services, and later elects to add these services and bill these services as a separate visit, must process the addition of these services as a Change in Scope of Service Request (CSOSR). A CSOSR must include a full fiscal year of RDH costs and visits.
  - IHS-MOA clinics are not subject to the CSOSR requirement.

Registered Dental Hygienist Scope

- Services in an SNC setting must comply with State Law:
  - Direct Supervision
  - General Supervision

Business & Professions Code, Chapter 4, Article 9

Covered/Non-Covered Benefits

- Not all dental services are covered benefits under Medi-Cal Dental.
- For details on which dental services are covered dental benefits refer to:
  - Medi-Cal Dental Provider Handbook
  - Manual of Criteria (MOC)

BILLABLE SERVICES

Standard of Care

DHCS

Standard of Care

- To improve efficiency and timely access to care, maintain quality of care for a patient, a treating dental provider shall, when applicable, feasible, and consistent with the standard of care, minimize the number of dental visits.
- Each patient should receive an individualized treatment plan that is safe, effective, patient centered and equitable.
- Documentation must justify deviation from the treatment plan

See the Provider Handbook Section 4 (Treating Members) for more information.

Standard of Care

- Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status.
- All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient centered, timely, and efficient manner.

See the Provider Handbook Section 4 (Treating Members) for more information

BILLABLE SERVICES

Visits

Visits: Face-to-Face Encounters Defined

- SNCs may render any dental service in a face-to-face encounter between a billable treating provider and an eligible member that is:
  - Within the scope of the treating dental practitioner's scope/licensure
  - Complies with the Medi-Cal Dental Manual of Criteria (MOC)
  - Determined to be "medically necessary" pursuant to the California Welfare & Institutions Code, Section 14059.5

See the Provider Handbook Section 4 (Treating Members) for more information.

Visits: Face-to Face Encounters, Qualifying Visits

- SNCs may bill a visit for dental services rendered to a Medi-Cal member even if the member also received services from another health professional on the same day.
  - Medi-Cal Provider Workbook
    Workbook_Medi-Cal Provider Training 2022: FQHC, RHC, Tribal FQHC & IHS-MOA Services (fqhc_2022)
  - Billing Codes
    Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes (rural cd) (ca.gov)
    Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes (tribal fqhc cd) (ca.gov)
  - Tribal Federally Qualified Health Centers
    Tribal Federally Qualified Health Centers (Tribal FQHCs) (tribal fqhc) (ca.gov)

Visits: Non-Qualifying Visits

- Visits at which the member receives services “incident to” resulting from physician or dental visits **do not** qualify as face-to-face encounters.
- Examples include:
  - Laboratory work
  - X-ray imaging
- Medi-Cal Provider Manual: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural)
- Medi-Cal Provider Workbook: Workbook_Medi-Cal Provider Training 2022: FQHC, RHC, Tribal FQHC & IHS-MOA Services (fqhc_2022)

Non-Emergency Visits, Children (Under 21 Years)

- Non-Emergency Visits typically includes:
  - Exam
  - X-rays
  - Cleaning/Prophylaxis
  - Fluoride
  - Oral Hygiene Instruction
  - Nutritional Counseling
  - Caries Risk Assessment
  - Behavioral Evaluation
- If more than one visit is required, documentation in the member's chart and/or electronic health records should indicate the necessity of any additional visits

Emergency Visits / Emergency Services

- The dentist should provide a definitive care plan during an emergency visit whenever possible
- For a list of allowable Medi-Cal emergencies, refer to the Medi-Cal Dental Provider Handbook, Section 5 - Manual of Criteria and Schedule of Maximum Allowances

Visits: Face-to-Face Encounters, Dental Services

Sealants:

- Providers should place sealants on as many eligible teeth as possible during the visit considering the clinical circumstances and member cooperation

Restorations, Extractions, or Endodontic Therapies:

- Providers should perform as many treatment planned services as possible during the visit, considering the clinical circumstances, what is ethical, and what is tolerable to the member

When Multiple Visits are Required

- Procedures normally requiring multiple visits should be consistent with the standard of care and the provider's scope of practice include, but not limited to:
  - Removable Dentures
  - Root Canals
  - Crowns
- If documentation is required in the member's chart and/or electronic health records must indicate the necessity of each visit

Definitive Services Not Completed During a Single Visit

- When definitive services are not completed within a single appointment, chart notes must be documented explaining why
- Examples include, but not limited to:
  - Periodic exams not done at the same time as a prophylaxis visit
  - Multiple visits to complete evaluation and discussion of treatment plan
  - Crown impression rendered on a different date than crown preparation
  - Not all sutures are removed in a single visit

BILLABLE SERVICES

Medical Necessity/Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

Medical Necessity – Adult Services

- A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to:
  - Protect Life
  - Prevent Significant Illness
  - Prevent Significant Disability
  - Alleviate Severe Pain

California Welfare & Institutions Code, Section 14059.5

EPSDT – Children's Services

- Consistent with state and federal law and regulations for EPSDT, Medi-Cal Dental covers all services that are medically necessary including those that are not a covered benefit, but are proven to "correct or ameliorate (make tolerable)" defects and physical and mental illnesses or conditions. These services are **without** cost for the member

See the EPSDT Information for Medi-Cal Dental Providers for more information.

Orthodontic Treatment - Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet

The HLD Score Sheet (DC016)

- The preliminary measurement tool used in determining if the member qualifies for medically necessary orthodontic treatment
- Must be kept on record and is required for all members receiving orthodontic treatment

See the Provider Handbook Section 9 (Special Programs) for more information.

Justification of Need for Prosthesis Form (DC054)

- The Medi-Cal Dental Manual of Criteria (MOC) defines situations in which dentures are covered benefits
- The Justification of Need for Prosthesis Form (DC054) is designed to provide complete and detailed information necessary for:
  - Dentures
  - Partial Dentures
  - Complete Overdentures
- DC054 must be kept on record and is required for all members receiving dentures

See the Provider Handbook Section 6 (Forms) for more information.

BILLABLE SERVICES

Documentation

Medi-Cal Dental

Documentation Requirements

- Every dentist, dental health professional, or other licensed health professional who performs a service on a member in a dental office shall identify himself or herself in the member record by signing his or her name, or an identification number and initials, next to the service performed and shall date those treatment entries in the record
- Any person licensed under this chapter who owns, operates, or manages a dental office shall ensure compliance with this requirement

California Business and Professions Code, Section 1683

Record Retention

» Record retention requirement is 10 years

Record keeping:

- Member information
- Date of service
- Each service rendered
- Any additional information required by DHCS

Electronic records:

- Member's information (including eligibility)
- Date of treatment
- Service performed
- Clear record of the rendering provider in the EHR system

California Welfare & Institutions Code, Section 14124.1

Authorization and Documentation Requirements

- SNC services **do not require** a Treatment Authorization Request (TAR)
- Providers **are required** to maintain the same level of documentation that is needed for authorization approval in the member's medical record
- Documentation for all SNC face-to-face encounters must be sufficiently detailed as to clearly indicate the medical reason for the visit

Documentation Requirements

- Documentation must include:
  - A complete description of service provided
  - Full name and professional title of the person providing the service
  - The pertinent diagnosis(es) as it relates to the visit
  - Any recommendations for diagnostic studies, follow up or treatments, including prescriptions
- The documentation must be kept in writing and for a minimum of ten years from date of service
- If documentation does not meet the requirements, DHCS may recover payments

Documentation Requirements

Providers must document any additional information including, but not limited to:

- Rationale and service provided for topical fluoride application outside the periodicity schedule
- Explanation of the emergency service not covered for a particular Medi-Cal member
- The extent and complexity of a surgical extraction not covered by Medi-Cal
- Justification for periodontal procedures include:
  - Medical necessity
  - Observations
  - Clinical findings
  - The specific treatment rendered
  - Medications or drugs used

See the Provider Handbook Section 8 (Fraud, Abuse, and Quality of Care) for more information.

Documentation Requirements: "But are not limited to"

- In the decision process and the administration of appropriate care, include pertinent records in documentation
- Other references:
  - American Dental Association – Dental Records
  - American Association of Pediatric Dentistry – Record Keeping

Documentation Requirements: Payment Recovery

» Payment recovery may occur when California Code of Regulations (CCR) requirements are not met

Examples include:

- Records and/or member charts are not complete or accurate
  (Title 22, Section 51476)
- Overpayments, including false/incorrect claim overpayments, member eligibility lapse, non-authorizes services, etc
  (Title 22, Section 51458.1)
- Services provided are below or less than the standard of acceptable quality
  (Title 22, Section 51472)

BILLABLE SERVICES

Treatment Plan and Phases

Treatment Plans Must:

- Optimize preventive and therapeutic care
- Be in the member's best interest and consider their overall health status
- Be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner

Treatment Plan: Examples of Inappropriate Plans

- Definitive services should be completed within a single appointment
- Examples of inappropriate plans/multiple visits without documented medical necessity would include, but not be limited to:
  - Periodic exams not done at the same time as a prophylaxis visit
  - Multiple visits to complete evaluation and discussion of treatment plan
  - Crown impression rendered on a different date than crown preparation
  - Crown build-ups done on a different date than preparation and impression
  - Not all sutures are removed in a single visit

Treatment Plan: Examples of Inappropriate Plans cont.

- Partial dentures started prior to the completion of caries control and periodontal therapy
- Extractions and crowns done shortly after the delivery of partial dentures
- Numerous and frequent consultations regarding the same tooth with no definitive treatment
- Numerous and frequent additional restorations on the same tooth
- More than 2 visits on a root canal

Three Levels of Prevention

- **Primary:** Preventing disease onsite or initiation
- **Secondary:** Preventing progression or disease recurrence
- **Tertiary:** Preventing loss of function

Treatment Plan: Phases 1-2

- **Phase 1: Urgent/Diagnostic**
  - Treatment of emergencies
  - Comprehensive examination
  - Diagnosis
  - Treatment plan
- **Phase 2: Disease Control**
  - Periodontal Therapy
  - Endodontic Therapy
  - Oral Surgery
  - Caries Control

Treatment Plan: Phases 3-4

- **Phase 3: Rehabilitation**
  - Orthodontic Therapy
  - Cast Restorations
  - Removable
- **Phase 4: Maintenance**
  - Recall, reassessment
  - Reinforced oral hygiene & diet

Treatment Plan

- Adherence to the treatment plan is expected
- Any alteration in the course of treatment should be well documented in the chart
- Clinical staff must document, prioritize, and update every member’s treatment plan at each visit.

BILLABLE SERVICES

Special Needs

Medi-Cal Dental

Members with Special Needs

- Members who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform an examination.
- Providers must adequately document the member's specific condition and reasons why an examination and treatment cannot be performed without sedation.

See the Provider Handbook Section 4 (Treating Members) for more information.

Members with Special Needs

- SNCs do not need to receive prior authorization for treatment
- Requests for payment must be accompanied by documentation to adequately demonstrate the medical necessity for treatment
- Refer to the Manual of Criteria and individual procedures for specific requirements and limitations

See the Provider Handbook Section 4 (Treating Members) for more information.

Members with Special Needs: Additional Documentation for Medical Necessity

- Accurate, comprehensive, and up-to-date medical history for current diagnosis and effective treatment planning
- Diagnosis and the nature of the special health care limitations
- Name of the physician, the date of the diagnosis, and the most current status and treatment updates
- Document the special accommodations that were required to treat the member (i.e., shorter and additional appointments are needed)

Contact Information

» dental@dhcs.ca.gov

Questions?

THANK YOU!

Medi-Cal Dental