California
Medi-Cal Dental

Basic and EDI Seminar Packet

Revised 05/09/2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Dear Medi-Cal Dental Provider and Staff:

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

The material contained in the training packet has been prepared to help familiarize you with Medi-Cal Dental's policies, procedures, and billing requirements. You should also refer to the Medi-Cal Dental 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

Medi-Cal Dental
P.O. Box 15609
Sacramento, CA 95852-0609
Phone (800) 423-0507 | www.dental.dhcs.ca.gov

State of California
Gavin Newsom, Governor

California Health and Human Services Agency

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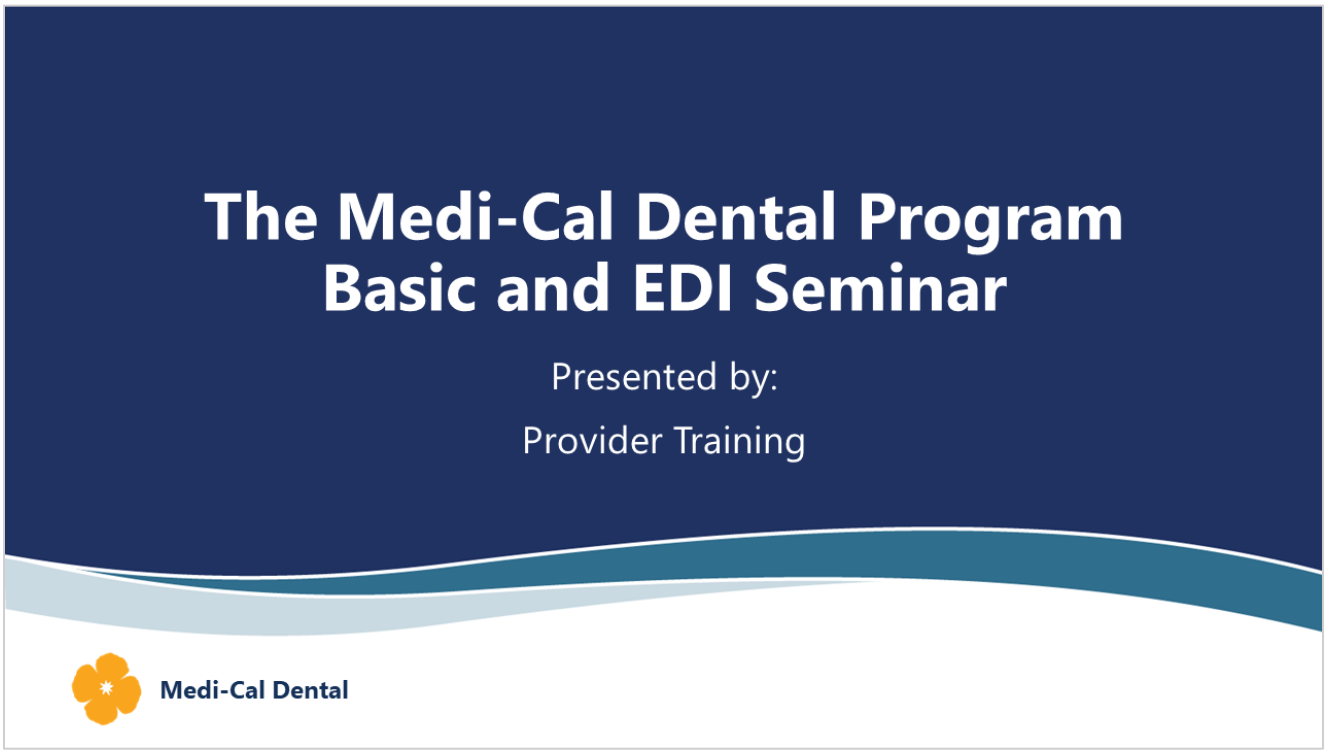
Introduction

This packet contains the information discussed in today's seminar regarding basic billing procedures and the use of forms. Please refer to Medi-Cal Dental Provider Handbook for detailed, step-by-step instructions on how to complete each form.

When discussing the Medi-Cal Dental program, some terminology may be unfamiliar. The back of the seminar packet contains a glossary listing some of the terms mentioned in today's seminar.



Program Overview

The primary objective of Medi-Cal Dental is to create a better dental care system and increase the quality of services available to those individuals and families who rely on public assistance to help meet their health care needs. Through expanding participation by the dental community and efficient, cost-effective administration of Medi-Cal Dental, the goal to provide quality dental care to Medi-Cal members continues to be achieved.

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
- California Code of Regulations (CCR), Title 22
- California Business and Professions Code – Dental Practice Act

Gainwell Technologies

» Administers:

- *Fee-For-Service* portion of the Medi-Cal Dental program for the Department of Health Care Services (DHCS)

» Provides:

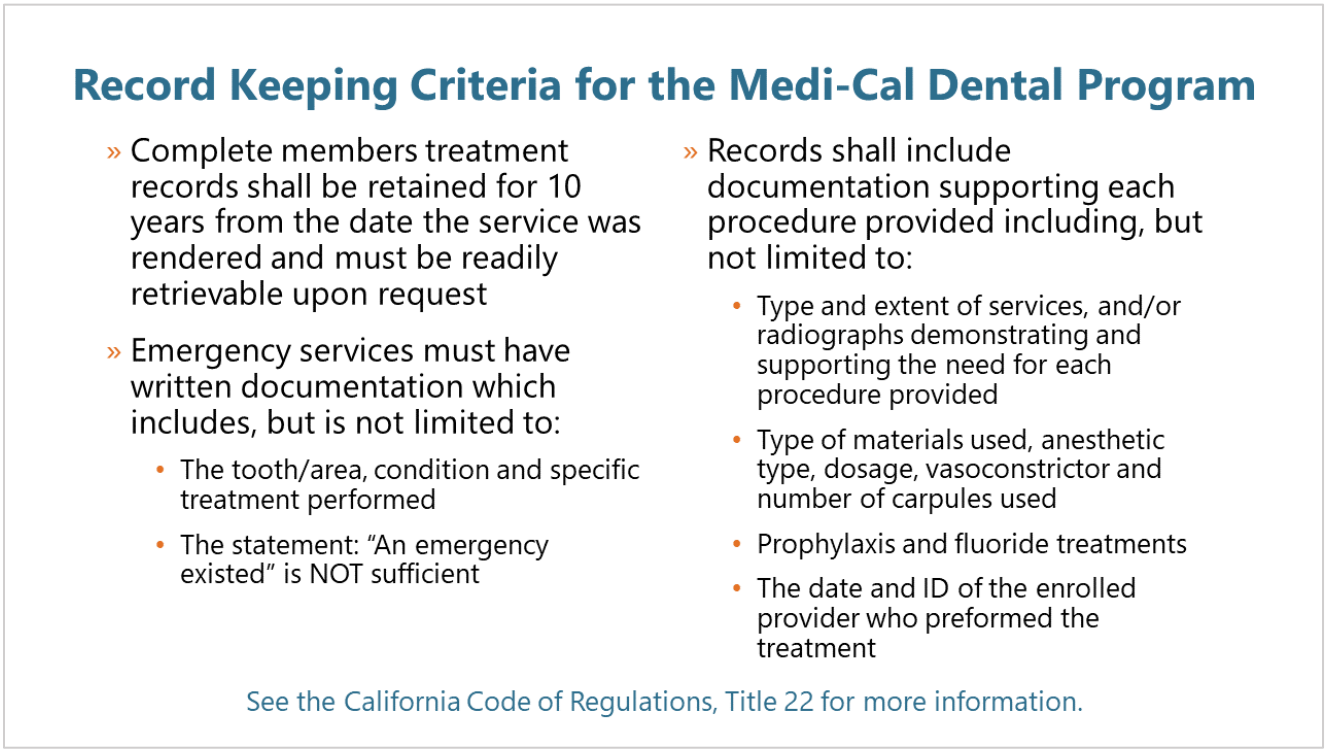
- Customer service
- Treatment Authorization Request (TAR) and Claim processing
- Distribution of checks
- Distribution of the Explanation of Benefits (EOB)
- Enforcement of the rules and guidelines set by DHCS

Record Keeping Criteria for the Medi-Cal Dental Program

Medi-Cal Dental's Compliance Management/Surveillance and Utilization Review (CM/SUR) department monitors for suspected fraud, abuse, and poor quality of care. In overseeing appropriate utilization in the program, the CM/SUR department helps Medi-Cal Dental meet its ongoing commitment to improving the quality of dental care for Medi-Cal members.

The goal of the CM/SUR department is to ensure that providers and members are in compliance with the criteria and regulations of Medi-Cal Dental. To achieve this goal, the CM/SUR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. Furthermore, department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard, and/or unnecessary treatment. Refer to the Provider Handbook Section 8 (Fraud) for more information.

Title 22, California Code of Regulations (CCR), established record keeping criteria for all Medi-Cal Dental providers:



Senate Bill 639

- Enhanced protections for Medi-Cal members
- Contains provisions regarding lines of credit between a provider and member
- Written treatment plan requirement:
  - Must indicate if Medi-Cal would cover an alternate medically necessary service
  - Must notify the Medi-Cal member that they have the right to ask for only services covered by Medi-Cal
  - The dentist must follow Medi-Cal rules to secure Medi-Cal covered services before treatment is rendered

See Bulletin Volume 36, Number 4 (March 2020) for more information.

Additional Services Offered by Medi-Cal Dental

Free Services Offered

- Interactive Voice Response System (IVR) - Gabby
  - Providers **800-423-0507** (Toll Free)
  - Members **800-322-6384** (Toll Free)
- Onsite Training Visits
- Seminars
- Case Management and Care Coordination Services
- American Sign Language (ASL) and Language Services

American Sign Language (ASL) and Language Services

- **ASL assistance** – available via telephone during or scheduled in advance for the appointment
- **Language interpreters** – available in 250 languages and dialects via telephone
- **Free language tagline signs** – available for providers / members with limited English

All providers and members can request these free ASL translation and language services and other assistance by calling the Customer Service Center

www.smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

Language Assistance Services

- Mon-Fri 8am-5pm
- Provider requesting a translator for a member call **800-423-0507**
- Member requesting a translator call **800-322-6384**
- Members with hearing or speaking limitations call:
  - Teletext Typewriter (TTY) line at **800-735-2922**
- At all other times members call the California Relay Service TDD/TTY at **711** to receive the help they need

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

Phone Numbers and Websites

Provider Toll-Free Line (Medi-Cal Dental)	800-423-0507
Medi-Cal Dental Website	www.dental.dhcs.ca.gov
Member Toll-Free Line (Medi-Cal Dental)	800-322-6384
Member Website	www.smilecalifornia.org
A.E.V.S. (to verify member 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
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 website:
https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx

NOTE:

- *Members may call the P.O.S./Internet help Desk to remove other health care coverage.*
- *Members may call the Health Care Options number to change managed care.*

Customer Service Inquiries

Provider Toll Free Telephone Number

For information or inquiries, providers may call the Customer Service Center toll-free at (800) 423-0507. Providers are reminded to have the appropriate information ready when calling, such as:

1. Member Name
2. Member Medi-Cal Identification Number
3. Billing Provider Name
4. Provider Number
5. Type of Treatment
6. Amount of Claim or TAR
7. Date Billed
8. Document Control Number
9. Check Number

Customer Service Center Agents are available Monday through Friday between 8:00 am and 5:00 pm, excluding holidays. Providers are advised to call between 8:00 am and 9:30 am, and 12:00 noon and 1:00 pm, when calls are at their lowest level.

Inquiries that cannot be answered immediately will be routed to a customer inquiry specialist. The question will be answered by mail within 10 days of the receipt of the original telephone call.

Member Toll-Free Telephone Number

If an office receives inquiries from members, please refer them to the Customer Service Center toll-free member number at (800) 322-6384. The member lines are available from 8:00 am to 5:00 pm Monday through Friday, excluding holidays.

Either members or their authorized representatives may use this toll-free number. Member representatives must have the member's name, BIC or CIN, and a signed Release of Information form on file with Medi-Cal Dental in order to receive information from Medi-Cal Dental.

The following services are available from Medi-Cal Dental by Member Services toll-free telephone operators:

1. A referral service to dentists who accept new Medi-Cal dental members
2. Assistance with scheduling and rescheduling Clinical Screening appointments
3. Information about Share of Cost (SOC) and copayment requirements of Medi-Cal Dental
4. General inquiries
5. Complaints and grievances
6. Information about denied, modified, or deferred Treatment Authorization Requests (TARs)

Interactive Voice Response System (IVR) - Gabby

The Medi-Cal Dental IVR, referred to as Gabby, is an automated inquiry system for use by providers. Providers can access Gabby by dialing the toll-free information line (800) 423-0507 from a touch tone telephone. Gabby is available 24 hours a day, 7 days a week for information that can be accessed without a provider number. The menu options that do not require entering a provider number include:

- Billing criteria for procedures most frequently inquired about by providers
- Upcoming schedule of provider seminars for the caller's area
- A monthly news flash consisting of items of interest to providers
- Information about ordering Medi-Cal Dental forms
- Information about enrollment in the Medi-Cal Dental Program
- Transfer to the customer service center for further inquiry

The hours for accessing information requiring a provider number are Monday through Sunday from 2:00 am to 12:00 midnight. The optimum time to call is between 6:00 am and 10:00 am or between 3:30 pm and 5:00 pm when calls are at their lowest level. The menu options that do require entering a provider number include:

- Patient history relative to specific service limited procedures
- Status of outstanding claims and/or TARs that the caller has submitted
- Provider financial information (next check amount and net earnings for the current or previous year)

Medicare/Medi-Cal Crossover Claims

Medicare will pay for certain dental services. See the Medicare/Medi-Cal Crossover Procedure Codes and Descriptions list in the Medi-Cal Dental Provider Handbook for procedures that qualify.

Medi-Cal Dental processes claims and TARs for Medicare covered dental services in accordance with the following Medicare/Medi-Cal crossover policies and procedures:

1. A provider must be enrolled with Medicare to bill Medi-Cal Dental for Medicare/Medi-Cal crossover services.
2. Medicare must be billed for Medicare covered services prior to billing Medi-Cal Dental. When billing Medi-Cal Dental, attach the EOMB to the claim form.
3. Approved and paid Medicare dental services do not require prior authorization by Medi-Cal Dental.
4. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a member has no direct bearing on the coverage or exclusion of any given dental procedure.

Hospital Cases

When dental services are provided in an acute care general hospital or a surgicenter, the provider must document the need for hospitalization (e.g., developmentally disabled, physical limitations, age, etc.).

To request authorization to perform dental-related hospital services, providers need to submit a TAR with radiographs/photos and supporting documentation to Medi-Cal Dental. Prior authorization is required only for the following services in a hospital setting: fixed partial dentures, removable prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from Medi-Cal Dental, even if the services are provided in an outpatient hospital setting. In all cases, an operating room report, or hospital discharge summary must be submitted with the claim for payment.

Services that require prior authorization may be performed on an emergency basis; however, the reason for the emergency services must be documented. Enclose a copy of the operating room report and indicate the amount of time spent in the operating room.

Hospital Inpatient Dental Services (Overnight or Longer)

If a provider is required to perform services within a hospital setting, the provision of the medical support services will depend on how the member receives their medical services. Members may receive medical services through several different entities:

- Medi-Cal Fee-For-Service (FFS)
- Geographic Managed Care (GMC)
- Medi-Cal Managed Care
- County Organized Health Systems (COHS)

Refer to the Provider Handbook Section 4 (Treating Members) for instructions on how to determine the entity providing a member's medical services.

Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the Medi-Cal (FFS) Program

Authorization is required from Medi-Cal to admit the member into the hospital.

This authorization must be submitted on the Medi-Cal Form 50-1, which should be sent directly to:

Department of Health Care Services
San Francisco Medi-Cal Field Office
P.O. Box 3704
San Francisco, CA 94119
(415) 904-9600

NOTE: *The Medi-Cal Form 50-1 should not be submitted to the Medi-Cal Dental program, this will only delay the authorization for hospital admission.*

If a member requires emergency hospitalization, a 'verbal' authorization is not available through the Medi-Cal field office. If the member is admitted as an emergency case, the provider may indicate in the Verbal Authorization Box on the Medi-Cal Form 50-1, "Consultant Not Available" (CNA). An alternative is to admit the member as an emergency case and submit the 50-1 retroactively within ten working days to the Medi-Cal field office.

A claim for payment of dental services is submitted to the Medi-Cal Dental program and must be accompanied by a statement documenting the need and reason the emergency service was performed. Include a copy of the operating room report.

Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans

The dentist must contact the member's medical plan to arrange for hospital or surgical enter admission and medical support services. All medical plans that provide services to Medi-Cal managed care members are contractually obligated to provide medical support services for dental treatment. If the Medi-Cal Field Office receives a Form Medi-Cal Form 50-1 for a Medi-Cal member who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

Mobile Dental Treatment Vans

Mobile dental treatment vans are considered, under Medi-Cal Dental, to be an extension of the provider's office and are subject to all applicable requirements of the program.

Maxillofacial-Orthodontic Services (MF-O)

All MF-O surgical and prosthetic services, TMJ dysfunction services, and services involving cleft palate/cleft lip require prior authorization. The exceptions to this are diagnostic services and those services performed on an emergency basis. Providers and their staff should be aware of the procedure codes specific to the MF-O program. To see to the codes, refer to the Provider Handbook Section 5 (Manual of Criteria and Schedule of maximum Allowances).

Orthodontic Services Program

Orthodontic benefits for eligible individuals under the age of 21 are available under California Medi-Cal Dental when medically necessary. Services must be performed by a qualified orthodontist who is enrolled as a Medi-Cal Dental provider. This program covers handicapping malocclusion, cleft palate/lip, and cranio-facial anomalies cases. A Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet must be submitted to document the medical necessity. Refer to the Provider Handbook Section 9 (Special Programs) for more information.

California Children's Services (CCS)

The CCS program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition. Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation.

All CCS dental/orthodontic providers must be enrolled and active in the Medi-Cal Dental program prior to receiving payment. If a provider has a valid authorization issued by the CCS program, the authorization will be honored through the expiration date. Continue using the same processing guidelines that were in place when the services were authorized.

CCS Program Guidelines

All CCS members are subject to the scope of benefits, prior authorization and processing guidelines as defined in the Medi-Cal Dental Provider Handbook. The CCS Program only authorizes dental services if such oral conditions affect the member's/CCS-eligible condition. Refer to the Provider Handbook Section 9 (Special Programs) for more information.

CCS/Medi-Cal Authorizations and Claims Processing

Members with CCS/Medi-Cal eligibility do not require a CCS SAR. These members have full scope Medi-Cal eligibility and are only case managed by CCS. No CCS SAR request should be submitted.

CCS/Medi-Cal claims and TARs are to be sent directly to Medi-Cal Dental. Providers may submit a TAR requesting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for a Medi-Cal member requiring dental benefits beyond the scope of Medi-Cal Dental.

CCS Only

CCS eligible members will continue to require service authorization requests (SARs) from CCS. Providers must request a SAR from the CCS county or regional office prior to submitting claims and TARs to Medi-Cal Dental.

The Professional Component

The Medi-Cal Dental program has a professional unit consisting of dental consultants who are licensed dentists. The consultants review all claims and TARs which require professional judgment. These dental consultants assist Medi-Cal Dental Provider/Member Services and Clinical Screening departments with reevaluations and special cases.

In addition, there are clinical screening dentists located throughout the state. They are responsible for pre-screening cases that may require clinical evaluation under the guidelines of the Medi-Cal Dental program.

After the clinical screening dentist has examined the patient, a Medi-Cal dental consultant reviews the screening report. The claim or TAR is subsequently approved, modified, or denied. The Medi-Cal Dental clinical screening dentists also do post-operative screenings.

Onsite Training Visit

Provider Field Representatives are available for onsite visits to assist providers with policy or billing issues that cannot be resolved by telephone or written correspondence. Medi-Cal Dental will determine the necessity to schedule an onsite training visit. To request a visit please contact the Customer Service Center at (800) 423-0507.

Seminars

There are four types of Medi-Cal Dental Seminars- Basic/EDI, Advanced, Workshops and Orthodontic. All seminars are free of charge and offer continuing education credits based on the hours of training conducted. Visit the Medi-Cal Dental website at www.dental.dhcs.ca.gov to make a reservation.

Case Management

Dental Case Management is available for those members who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers. Case management services are intended for members with significant medical, physical, and/or behavioral diagnosis. Referrals for case management services are initiated by the member's medical provider, dental provider, case worker or healthcare professional and are based on a current, comprehensive evaluation and treatment plan.

The Case Management referral form is located on the Medi-Cal Dental website: www.dental.dhcs.ca.gov Members must be referred by a Medical or Dental professional by completing the secure online referral form. If you have questions when submitting an online referral, please contact the Customer Service Center at (800) 423-0507. Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Care Coordination Services

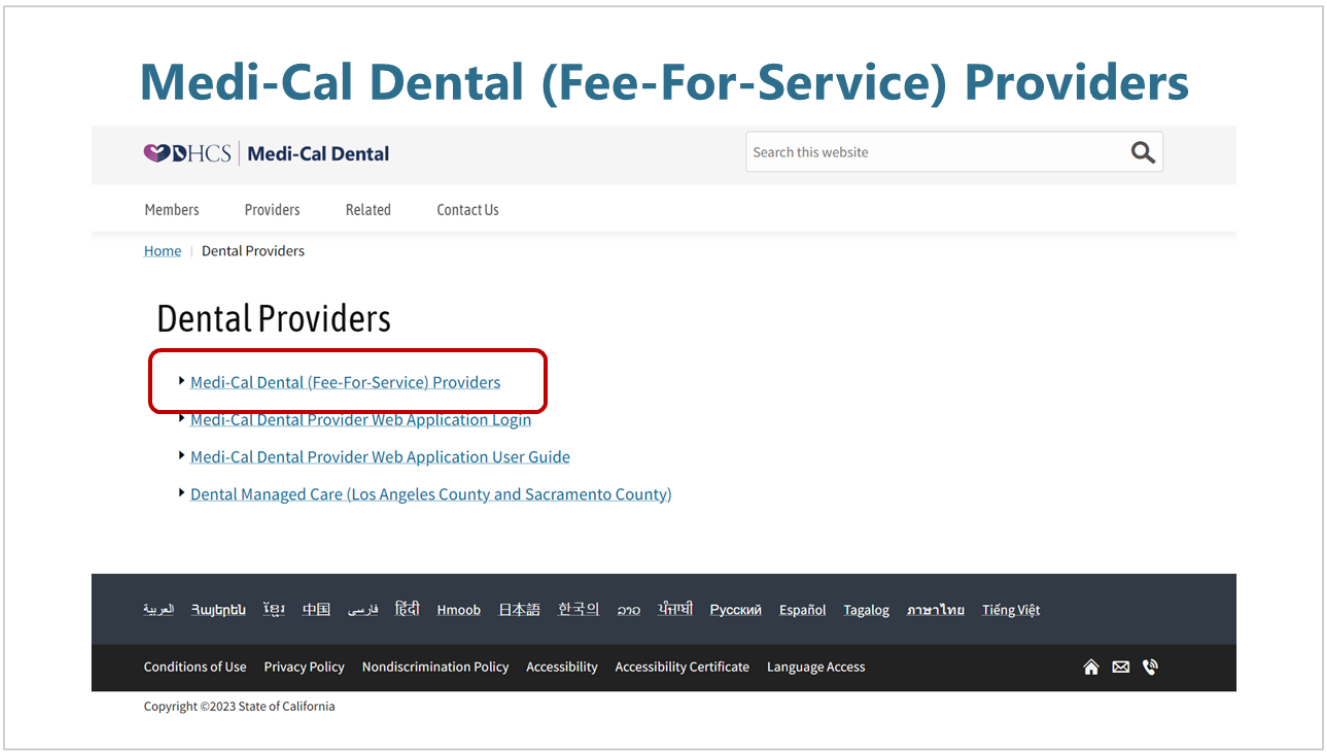
Care Coordination services are offered by the Customer Service Center (CSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our CSC agents, who assist members with: Locating a General or Specialist Dentist, Accessing Appointments, Translation Services, Transportation Assistance. Members can access the Care Coordination Services by contacting the Customer Service Center at (800) 322-6384, and request Care Coordination assistance.

The Medi-Cal Dental Provider Website

The Medi-Cal Dental Provider Handbook and Medi-Cal Dental Bulletins are available on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

The Provider Handbook has been developed to assist the provider and office staff with participation in the Medi-Cal Dental program. It contains detailed information regarding the submission, processing and completion of all treatment forms and other related documents. The Provider Handbook should be used frequently as a reference guide to obtain the most current criteria, policies, and procedures of the California Medi- Cal Dental Program.

The Medi-Cal Dental Bulletins are published periodically to keep providers informed of the latest developments in the program. New bulletins will appear in the “What’s New Section” of the Medi-Cal Dental website and are incorporated into the “Provider Bulletins” section of the website. This section should be checked frequently to ensure that your office has the most updated information on the Medi-Cal Dental program.


Medi-Cal Dental (Fee-For-Service) Providers
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Contact Us
Home | Dental Providers
Dental Providers
Medi-Cal Dental (Fee-For-Service) Providers
Medi-Cal Dental Provider Web Application Login
Medi-Cal Dental Provider Web Application User Guide
Dental Managed Care (Los Angeles County and Sacramento County)
العربية Հայերեն ខ្មែរ 中国 فارسی हिंदी Hmoob 日本語 한국의 ລາວ ਪੰਜਾਬੀ Русский Español Tagalog ภาษาไทย Tiếng Việt
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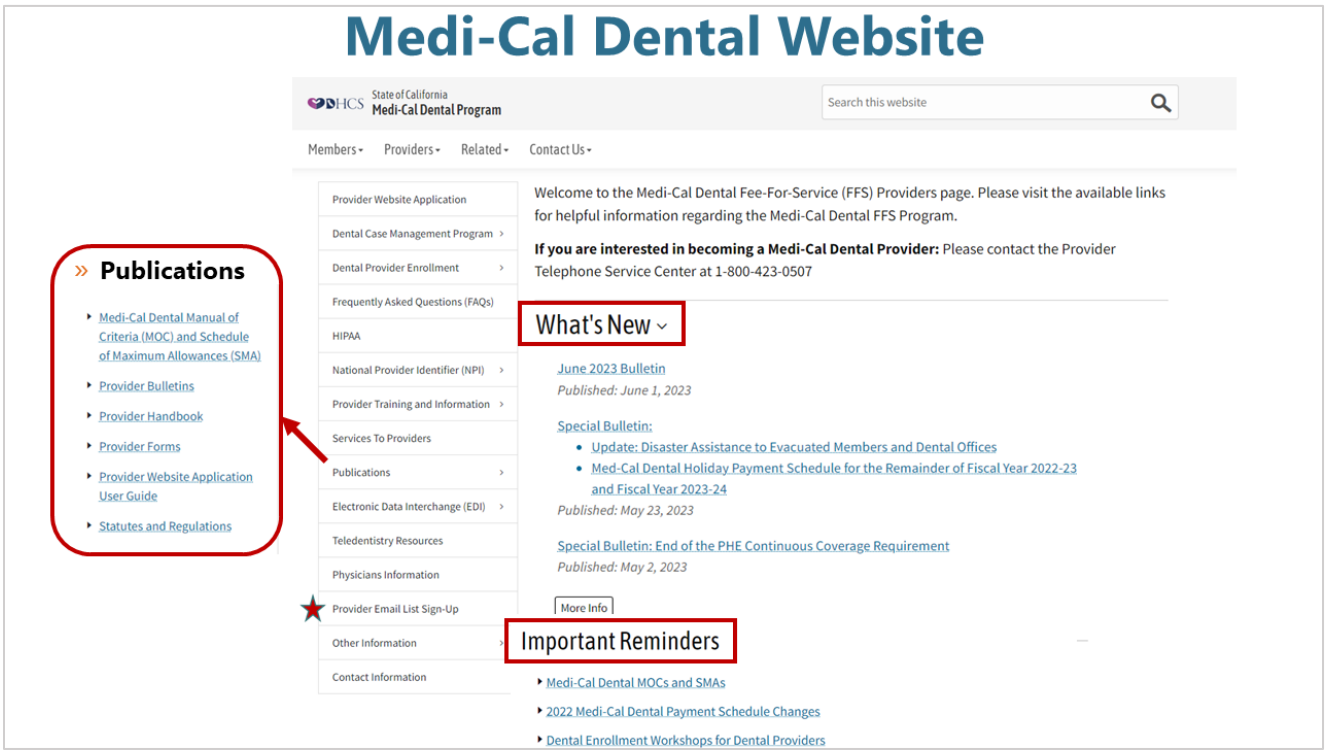

Medi-Cal Dental Website
DHCS State of California Medi-Cal Dental Program
Search this website
Members
Providers
Related
Contact Us
Provider Website Application
Dental Case Management Program
Dental Provider Enrollment
Frequently Asked Questions (FAQs)
HIPAA
National Provider Identifier (NPI)
Provider Training and Information
Services To Providers
Publications
Electronic Data Interchange (EDI)
Teledentistry Resources
Physicians Information
Provider Email List Sign-Up
Other Information
Contact Information
Publications
Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA)
Provider Bulletins
Provider Handbook
Provider Forms
Provider Website Application User Guide
Statutes and Regulations
Welcome to the Medi-Cal Dental Fee-For-Service (FFS) Providers page. Please visit the available links for helpful information regarding the Medi-Cal Dental FFS Program.
If you are interested in becoming a Medi-Cal Dental Provider: Please contact the Provider Telephone Service Center at 1-800-423-0507
What's New
June 2023 Bulletin
Published: June 1, 2023
Special Bulletin:
Update: Disaster Assistance to Evacuated Members and Dental Offices
Med-Cal Dental Holiday Payment Schedule for the Remainder of Fiscal Year 2022-23 and Fiscal Year 2023-24
Published: May 23, 2023
Special Bulletin: End of the PHE Continuous Coverage Requirement
Published: May 2, 2023
More Info
Important Reminders
Medi-Cal Dental MOCs and SMAs
2022 Medi-Cal Dental Payment Schedule Changes
Dental Enrollment Workshops for Dental Providers

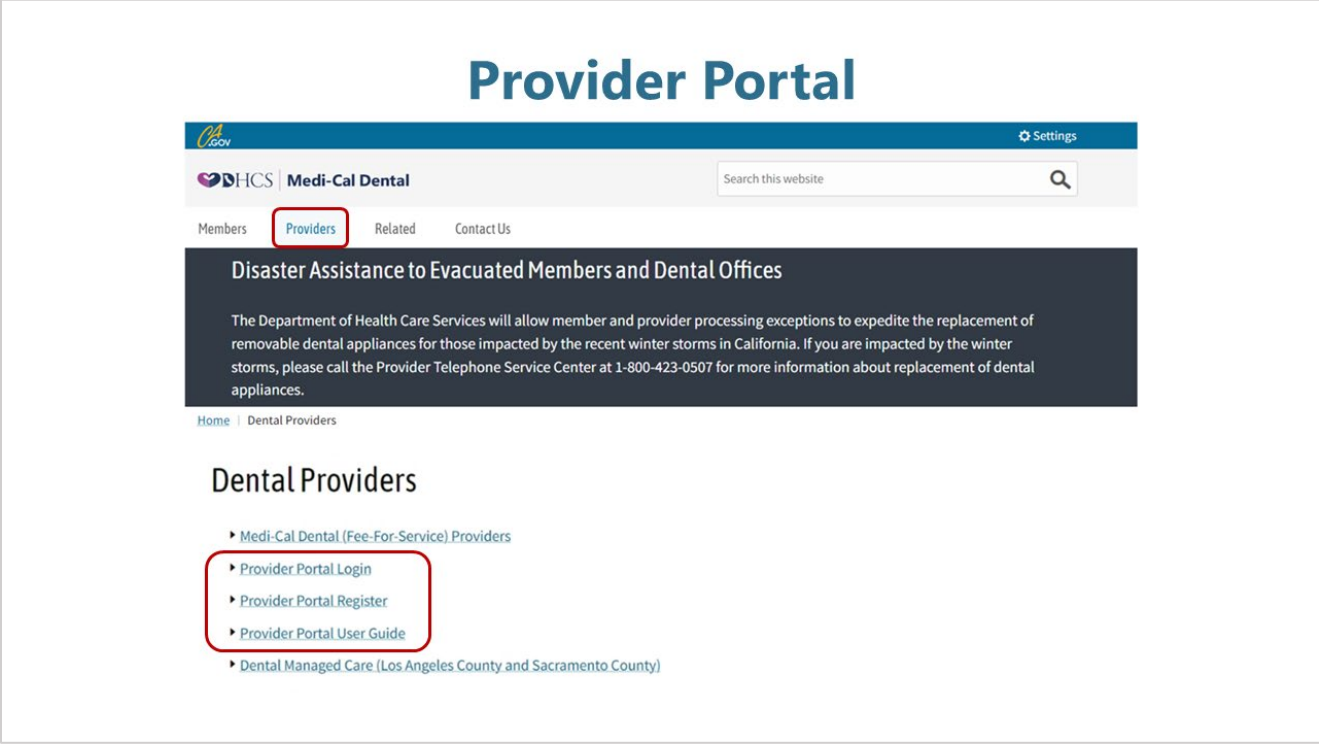
Medi-Cal Dental Provider Portal

Registered providers can check Medi-Cal Dental member's history online. This feature will display all dental services that a member received from Medi-Cal dental providers in the last five years, with individual provider information hidden. Each line item will include:

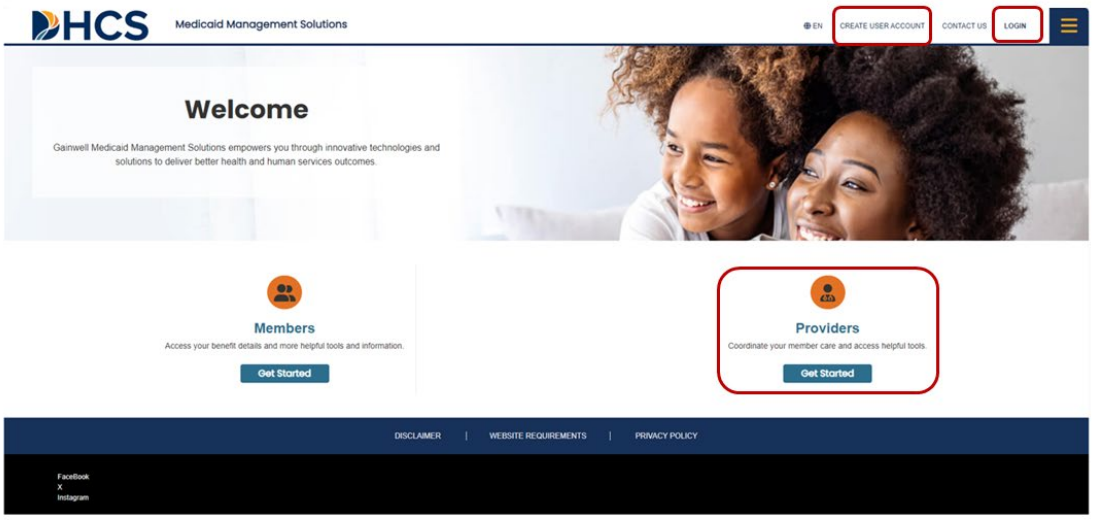
- Tooth information
- Procedure(s)
- Dates of service
- Denied/allowed status

Providers can also use the Provider Portal to access other important Medi-Cal Dental information, such as:

- Claim status and history
- Treatment Authorization Request status and history
- Weekly check amounts
- Monthly payment totals and year-to-date payment



Login Provider Portal



Enrollment

Enrollment: Become a Medi-Cal Provider

- To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the Medi-Cal Dental Program
- Enrollment is through the Provider Enrollment Division (PED) of DHCS
  - PED uses an online application portal called the Provider Application and Validation for Enrollment (PAVE)
  - Paper applications are not accepted!

PAVE Application: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Provider Application and Validation for Enrollment (PAVE) Portal

- Enrollment:
  - PAVE is for Providers who want to enroll in Medi-Cal Fee-for-Service
- Enrollment Changes:
  - All changes to your practice and/or license must be completed through PAVE
  - This must happen within 35 days of the change
- Enrollment Revalidation
  - DHCS will notify providers when revalidation is necessary

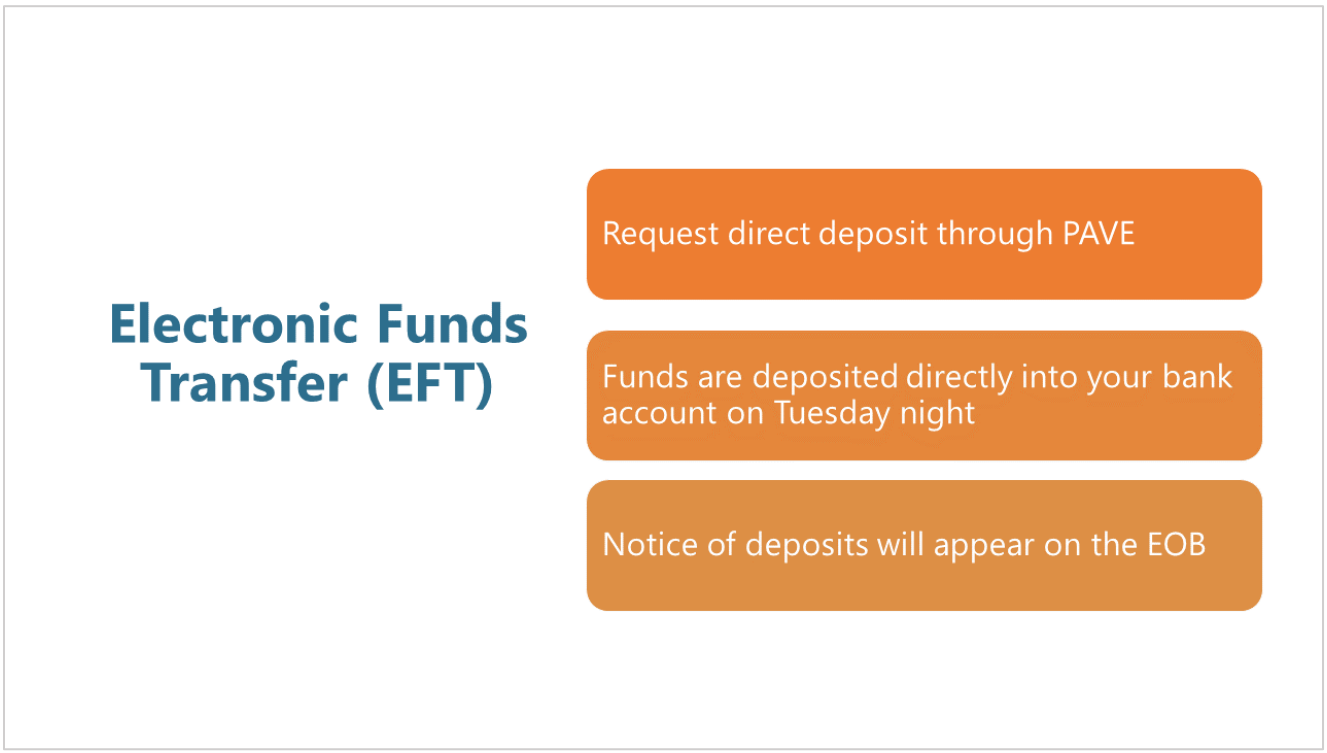
Enrollment: Welcome Packet

- Newly enrolled billing provider receives:
  - Billing Provider Number
  - Personal Identification Number (PIN)
  - Starter packet of forms
    - Re-order additional forms on the Medi-Cal Dental Website

Enrollment: Revalidation Process

- State regulations mandate that all providers are required to re-validate every 5 years to continue participating in the Medi-Cal Dental Program
- DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application
- Dental providers submit revalidation applications using PAVE

See PED website or PED Message Center for more information.



Billing Providers

To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the Medi-Cal Dental Program. On October 31, 2022, DHCS implemented the Provider Application and Validation for Enrollment (PAVE) Provider Portal to simplify and accelerate Medi-Cal enrollment processes for dental providers. The PAVE portal is a web-based application that allows dental providers to submit enrollment applications and required documentation to DHCS electronically.

PAVE website: Provider Enrollment Division (PED) (ca.gov)

NOTE*: Paper applications are not accepted and will be returned.*

Once the enrollment process is complete, the new Billing Provider will be informed of acceptance into the program which will include the Billing Provider number and a Personal Identification Number (PIN).

The new Billing Provider will also receive a starter packet of forms. Additional forms may be ordered by completing the Forms Re-order Request form found on the Medi-Cal Dental Website. Medi-Cal Dental Forms Reorder Request

Rendering Providers

Each provider who treats Medi-Cal members must be enrolled in the Medi-Cal Dental program. The Rendering Provider number will be the type 1 NPI number that the Dr. obtained from NPPES. Group and rendering providers will be required to complete an affiliation form within PAVE. The Rendering Provider number will go in Box 33 on your Claims and NOAs.

Billing Intermediaries

Medi-Cal Dental accepts claims prepared and submitted by a billing service acting on behalf of a provider. The provider and billing service must complete the Medi-Cal Dental Provider and Billing Intermediary Application/Agreement found on the Medi-Cal Dental website. Once the process is complete, the billing service will receive a registration number which must be included on all claim forms they submit on a doctor's behalf.

Enrollment Assistance

For Medi-Cal provider enrollment information, contact the Provider Enrollment Division (PED) using the Inquiry Form on PED's website under Provider Resources.

- https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Providers can also contact the PED's Message Center:

- Phone Number (916) 323-1945
- Email PAVE@dhcs.ca.gov
- Send a message in PAVE

PAVE Technical Support (excluding State holidays)

For PAVE technical support, please call the PAVE Help Desk at (866) 252-1949.

- Help Desk is available Monday-Friday from 8:00 am – 6:00 pm

PAVE Chat feature (excluding State holidays)

Providers can also use the PAVE Chat feature for support while in PAVE.

- Chat is available Monday-Friday from 8:00 am – 4:00 pm

Billing Inquiries and PIN Inquiries

Billing and EFT Inquiries

Please call the Customer Service Center (CSC) at (800) 423-0507.

- CSC Agents are available Monday-Friday from 8:00 am – 5:00 pm
- Excluding State holidays

PIN Confirmation/Reset

A PIN cannot be confirmed or reset over the telephone. To confirm or reset a PIN, send a written request to:

Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

Eligibility

Eligibility

- Eligibility is established by the County Department of Social Services
  - Information is transferred to the Department of Health Care Services (DHCS)
- Benefits Identification Card is issued
- Eligibility is established on a monthly basis
  - Providers must verify a member's eligibility for each month the member is receiving services
- Eligibility Verification Confirmation Number (EVC)

Members Turning 21 Years of Age

- Benefit changes on the day they turn 21
- Authorization for services that were approved prior to the member's 21st birthday, may still be provided as long as:
  - The member continues to have Medi-Cal eligibility
  - The procedures were approved
  - Must be completed within the 180 days window as allowed on the Notice Of Authorization (NOA)

Medi-Cal Members Identification

The BIC is a permanent plastic card issued once. The front of the card contains the member's ID number, name, birth date and issue date. The reverse side contains a magnetic strip and member's signature area.

Verifying Member Identification

Members are required to sign their Benefits Identification Card (BIC) prior to presenting the card for services. Members who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. If a provider does not attempt to identify a member and provides services to an ineligible member, payment for those services may be disallowed. In certain instances, no identification verification is required, for example:

- When the member is 17 years of age or younger
- When the member is receiving emergency services
- When the member is a resident in a long-term care facility

If the member is unknown to the provider, the provider is required to make a "good-faith" effort to verify the member's identification by matching the name and signature on the Medi-Cal issued ID to that on a valid photo identification, such as:

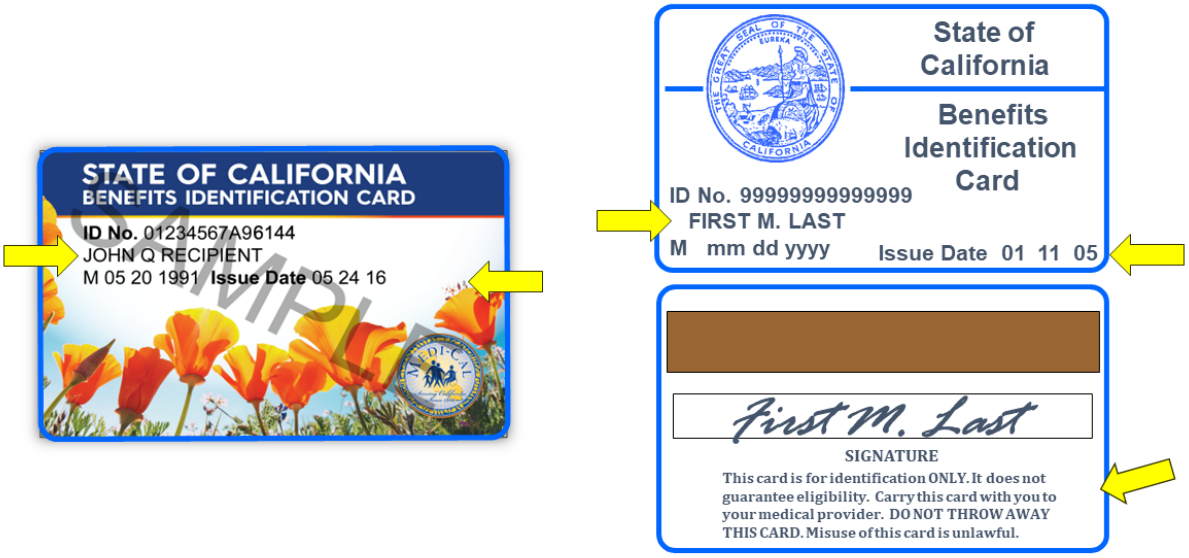
- A California driver's license
- An identification card issued by the Department of Motor Vehicles
- Any other document which appears to validate and establish identity

Medi-Cal dental providers must now accept expired photo identification (ID) up to six months from the date of expiration to verify a Medi-Cal patient's eligibility. During this grace period, providers may not deny Medi-Cal patients service for an expired ID.

NOTE: *The provider must retain a copy of this identification in the member's records*.

Any provider who suspects a member of abusing Medi-Cal Dental may call (800) 822-6222, Monday through Friday between 8:00 am and 5:00 pm

Medi-Cal Benefits Identification Card (BIC)



Medi-Cal Benefits Identification Card (BIC)

- The Benefits Identification Card contains information to enable providers to access eligibility
  - NOT a verification of eligibility
  - NOT guarantee for payment
  - Make a copy of the BIC for the member record
- Verification of Identification
  - All paper cards (Immediate Need, CHDP, Presumptive Eligibility Cards) are used for ID purposes only.
  - Make a copy of the ID for the member record
  - Verification of Identification Exceptions

Verifying Eligibility

- The Medi-Cal program verifies member eligibility
  - Verify eligibility and current Share of Cost (SOC) information
- The Point of Service (POS) Network is available 22 hours a day, 7 days a week
- 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

Request Access to the Eligibility Website

- Providers must have a POS Network/Internet Agreement on file to access the eligibility website
- The POS Network/Internet Agreement can be attained from:
  - Medi-Cal website: www.medi-cal.ca.gov

Verifying Eligibility

Providers must verify eligibility every month for each member who presents a BIC, paper Immediate Need or Minor Consent card. A provider who declines to accept a Medi-Cal member must do so before accessing eligibility information with the exceptions listed in the Handbook. The State of California Department of Health Care Services (DHCS) will also review claims to determine providers who establish a pattern of providing services to ineligible members or individuals other than the member indicated on the BIC.

Options to Access the Point of Service (POS) Network

The POS is set up to verify eligibility and perform Share of Cost (SOC) transactions. The network may be accessed through the following ways:

Touch-tone Telephone Access

With the use of an assigned PIN, all providers with a touch-tone telephone may access the Medi-Cal Automated Eligibility Verification System (AEVS). The automated system will provide eligibility and Share of Cost (SOC) information that is current and up to date. AEVS is accessible 22 hours a day, 7 days a week. The toll-free number to access AEVS is (800) 456-AEVS (2387). Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Internet Access

The Medi-Cal website www.medi-cal.ca.gov allows providers to verify eligibility and update Share of Cost liability. This secure site is accessed by using the billing provider number and PIN.

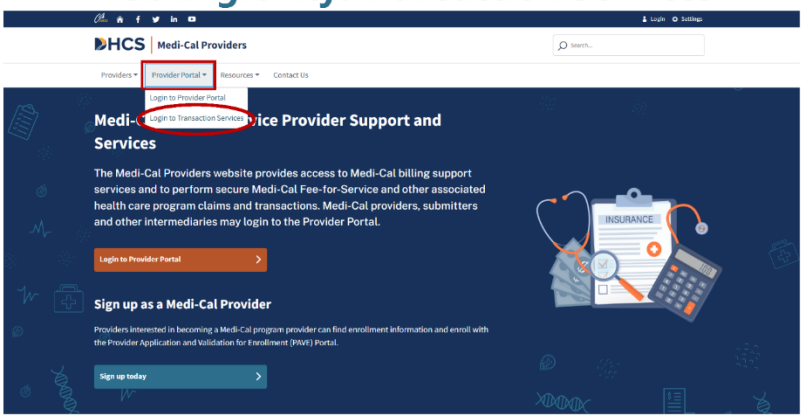
Custom Applications

Providers with large claim volume and extensive computer systems may require custom applications to allow their system to interface with the POS network. The technical specifications to develop the program are available at no charge. The same eligibility and SOC information will be available to those using this method.

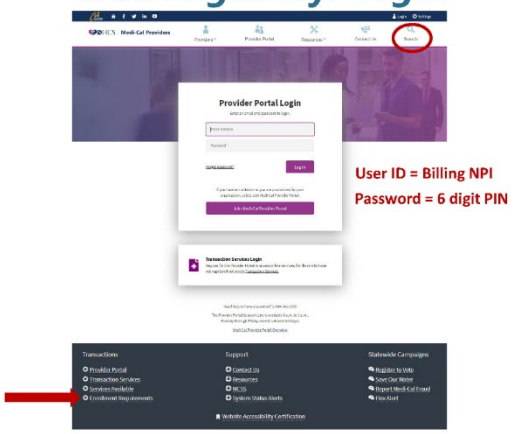
Eligibility Verification Confirmation (EVC)

If the member's eligibility has been established for the month requested, an EVC number is received. This number should be recorded in the patient record. Please enter the EVC number in the field available on the Treatment Authorization Request (TAR)/Claim form, or in Box 23 on the Notice Of Authorization (NOA).

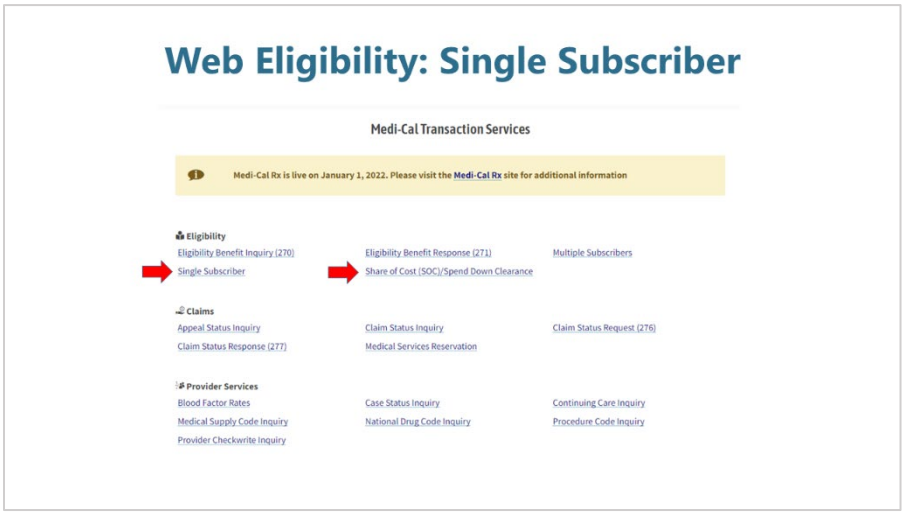
Web Eligibility: Transaction Services



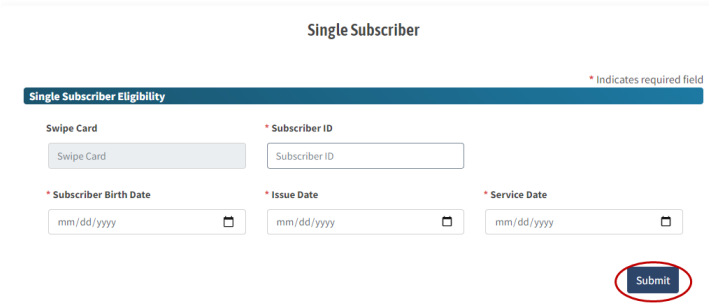
Web Eligibility: Login



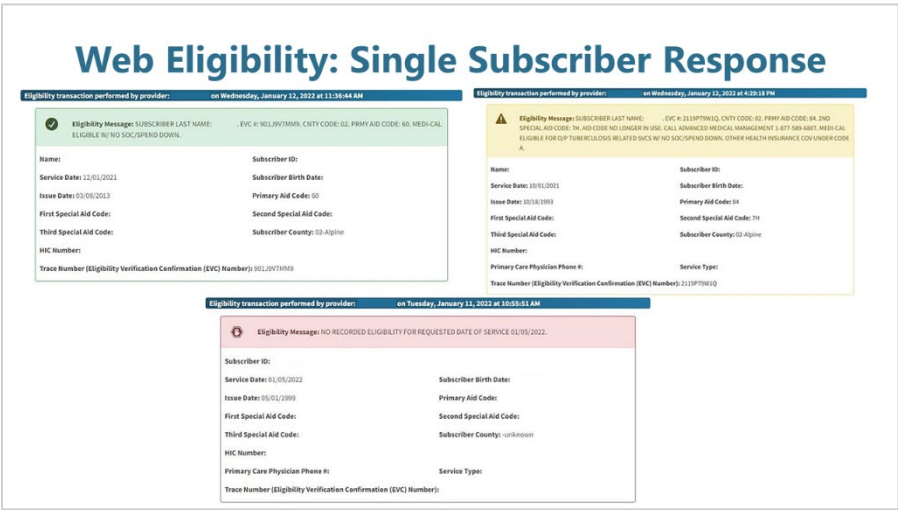
Web Eligibility: Single Subscriber



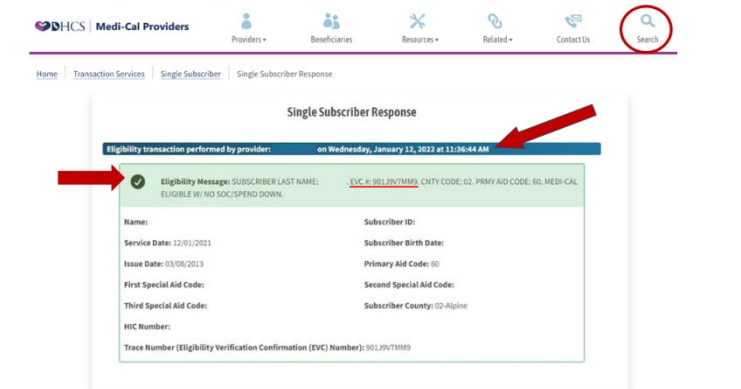
Web Eligibility: Single Subscriber



Web Eligibility: Single Subscriber Response

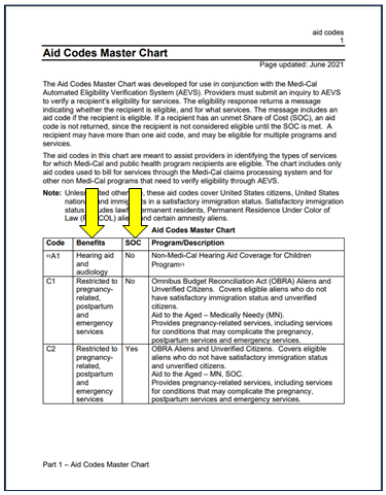


Web Eligibility: Single Subscriber Response



Aid Code Master Chart

- The Aid Code Master Chart lists each Aid Code with columns for:
  - Type of Benefits
  - Share of Cost



aid codes
1

Aid Codes Master Chart

Page updated: June 2021

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Automated Eligibility Verification System (AEVS). Providers must submit an inquiry to AEVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the SOC is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

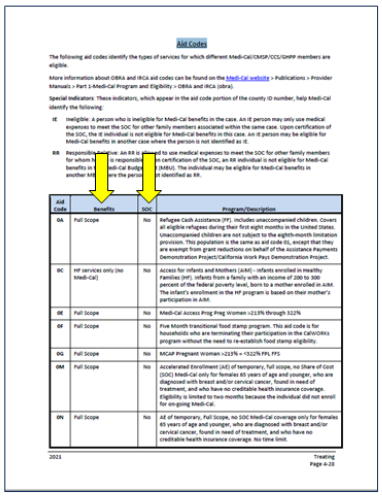
The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and public health program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing system and for other non Medi-Cal programs that need to verify eligibility through AEVS.

Note: Unless [illegible] other[illegible], these aid codes cover United States citizens, United States nation[illegible] and immi[illegible]s in a satisfactory immigration status. Satisfactory immigration status [illegible]udes lawf[illegible]ermanent residents, Permanent Residence Under Color of Law ([illegible]COL) alie[illegible]nd certain amnesty aliens.

Aid Codes Master Chart

Code	Benefits	SOC	Program/Description
+A1	Hearing aid and audiology	No	Non-Medi-Cal Hearing Aid Coverage for Children Program+
C1	Restricted to pregnancy-related, postpartum and emergency services	No	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – Medically Needy (MN). Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C2	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Part 1 – Aid Codes Master Chart



Aid Codes

The following aid codes identify the types of services for which different Medi-Cal/CMSP/CCI/GHPP members are eligible.

More information about OBRA and IRCA aid codes can be found on the Medi-Cal website > Publications > Provider Manuals > Part 1-Medi-Cal Program and Eligibility > OBRA and IRCA (obra).

Special Indicators: These indicators, which appear in the aid code portion of the county ID number, help Medi-Cal identify the following:

IE Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR Responsible Relative: An RR is [illegible]required to use medical expenses to meet the SOC for other family members for whom he/she is responsible[illegible]n certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in [illegible]Medi-Cal Budget [illegible]3486). The individual may be eligible for Medi-Cal benefits in another M[illegible]ere the person is identified as RR.

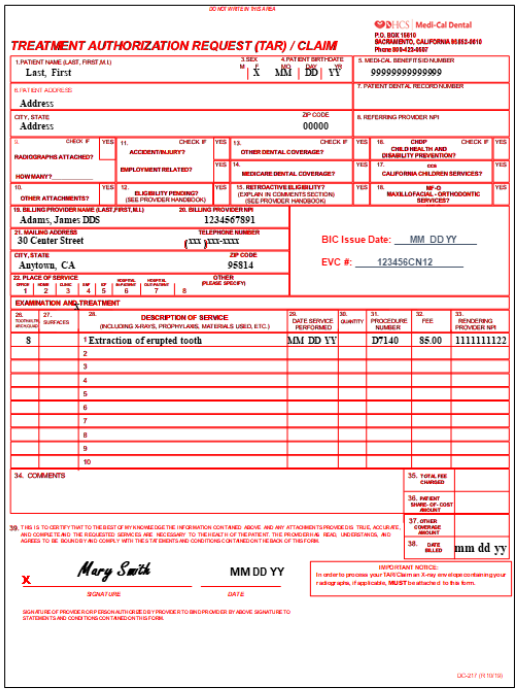
Aid Code	Benefits	SOC	Program/Description
0A	Full Scope	No	Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 0L, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	HF services only (no Medi-Cal)	No	Access for infants and Mothers (AIM) - infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
0E	Full Scope	No	Medi-Cal Access Prog Preg Women >213% through 322%
0F	Full Scope	No	Five Month transitional food stamp program. This aid code is for households who are terminating their participation in the CalWORKs program without the need to re-establish food stamp eligibility.
0G	Full Scope	No	MCAP Pregnant Women >213% < =322% FPL FPS
0M	Full Scope	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.
0N	Full Scope	No	AE of temporary, Full Scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. No time limit.

2021 Treating Page A-20

See the Provider Handbook Section 4 or the Medi-Cal website for the Aid Code Master Chart.

Aid Codes

- Not everyone receiving Medi-Cal has full-scope benefits:
  - Limited Services
  - Restricted Services



DO NOT WRITE IN THIS AREA

Medi-Cal Dental
P.O. BOX 15910
SACRAMENTO, CALIFORNIA 95852-0910
Phone: 800-423-0507

TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.): Last, First
3. SEX: M X
4. PATIENT BIRTH DATE: MM DD YY
5. MEDI-CAL BENEFITS ID NUMBER: 9999999999999
6. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER
CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI
9. RADIOGRAPHS ATTACHED? CHECK IF YES
11. ACCIDENT/INJURY? CHECK IF YES
EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? CHECK IF YES
14. MEDICARE DENTAL COVERAGE? YES
16. CHDP/CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
17. CALIFORNIA CHILDREN SERVICES? YES
HOW MANY?
10. OTHER ATTACHMENTS? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.): Adams, James DDS
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: (xxx) xxx-xxxx
CITY, STATE: Anytown, CA
ZIP CODE: 95814
22. PLACE OF SERVICE: OFFICE 1, HOME 2, SNF 3, ICF 4, SDC 5, HOSPITAL (NON-RESIDENT) 6, HOSPITAL (RESIDENT) 7, OTHER (PLEASE SPECIFY) 8
BIC Issue Date: MM DD YY
EVC #: 123456CN12

EXAMINATION AND TREATMENT

25. TOOTH NO. (IF APPLICABLE)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
8		1 Extraction of erupted tooth	MM DD YY		D7140	$$.00	1111111122
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS
35. TOTAL FEE CHARGED
36. PATIENT SHARE-OF-COST AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED: mm dd yy

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE TERMS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X Mary Smith — SIGNATURE
MM DD YY — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO SIGN PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTICE: In order to process your TAR/Claim an X-ray envelope must be attached to this form.

DC-217 (R 10/19)

Emergency Services

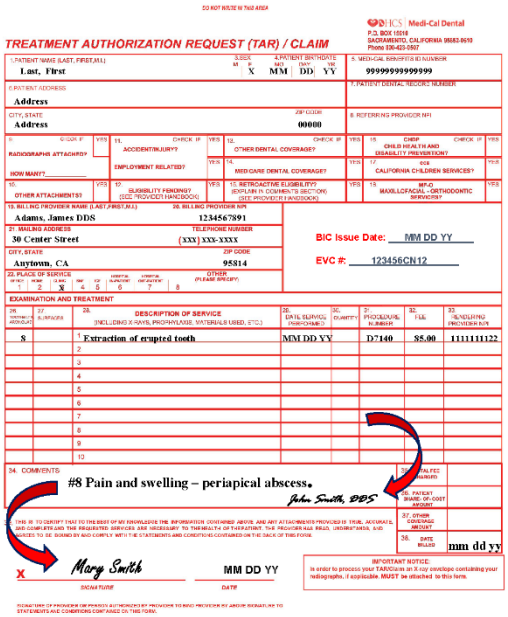
Emergency Services require:

» Emergency Certification Statement

» Two signatures

Emergency services aid codes for OBRA members:

» Must contain specific emergency procedures, regardless of age.



TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

Medi-Cal Dental

P.O. BOX 15016
SACRAMENTO, CALIFORNIA 95852-9016
Phone 800-423-0507

1. PATIENT NAME (LAST, FIRST, M.I.): Last, First
3. SEX: X
4. PATIENT BIRTHDATE: MM DD YY
5. MEDICAL SUPPORTED ID NUMBER: 999999999999
6. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER
CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI
9. RADIOGRAPHS ATTACHED?
10. ACCIDENT/INJURY?
11. OTHER DENTAL COVERAGE?
12. CHDP CHILD HEALTH AND DISABILITY PREVENTION?
HOW MANY?
EMPLOYMENT RELATED?
13. MEDICARE DENTAL COVERAGE?
14. CCS CALIFORNIA CHILDREN SERVICES?
15. OTHER ATTACHMENTS?
16. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)
17. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)
18. MFC MAXILLOFACIAL - ORTHODONTIC SERVICES?
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.): Adams, James DDS
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: (XXX) XXX-XXXX
CITY, STATE: Anytown, CA
ZIP CODE: 95814
BIC Issue Date: MM DD YY
EVC #: 123456CN12
22. PLACE OF SERVICE
OTHER (PLEASE SPECIFY)
EXAMINATION AND TREATMENT

25. PAYMENT ADJUST.	27. S-SPACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
S		1 Extraction of erupted tooth	MM DD YY		D7140	$5.00	1111111122
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS: #8 Pain and swelling – periapical abscess. John Smith, DDS
35. TOTAL FEE AMOUNT
36. PATIENT PAID AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED: mm dd yy
I CERTIFY TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.
X Mary Smith
SIGNATURE
MM DD YY
DATE
IMPORTANT NOTICE: In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, MUST be attached to this form.
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

See the Provider Handbook Section 10 (CDT 23 Tables) for a list of allowable procedure codes.

Managed Care Plans

» Patient must go to a plan provider:

Eligibility Message: SUBSCRIBER LAST NAME: XXXXXX. EVC# 00000AKEOR. CNTY CODE: 19. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER:PHP-HLTH NET: MEDICAL CALL (800)000-0000. HPC: CALL (800) 000-0000 FOR HCP INFORMATION. PCP: DR. XXXXX XXXX CALL (000) 000-0000.
ACCESS DENTAL PLAN: DENTAL CALL (000) 000-0000.

Subscriber Name: LAST, FIRST M.	**Subscriber ID:** 90000000A
Subscriber Birth Date: MM/DD/YYYY	**Issue Date:** MM/DD/YYYY
Primary Aid Code: 00	**First Special Aid Code:**
Second Special Aid Code:	**Third Special Aid Code:**
Responsible County: 19 – Los Angeles	**Medicare ID:** XXXXXXXXXXX
Primary Care Physician Phone:	**Service Type:**
Service Date: MM/DD/YYYY	**Trace Number (Eligibility Verification Confirmation (EVC) Number:** OOOOOAKEOR

Other Insurance Coverage

- Prepaid Health Plans (PHP) / Health Maintenance Organization (HMO)
- Indemnity Plans
- Medi-Cal Dental is always secondary carrier
- Other Coverage must be billed first

Eligibility Message: SUBSCRIBER LAST NAME: XXXXXX. EVC# OOOOOAKEOR. CNTY CODE: 11. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV. UNDER CODE V. CARRIER NAME: BLUE CROSS OF CALIFORNIA ID XXXX000XXX00. COV COMIPDVR	
Subscriber Name: LAST, FIRST M.	**Subscriber ID:** 90000000A
Subscriber Birth Date: MM/DD/YYYY	**Issue Date:** MM/DD/YYYY
Primary Aid Code: 00	**First Special Aid Code:**
Second Special Aid Code:	**Third Special Aid Code:**
Responsible County: 11– Glenn	**Medicare ID:** XXXXXXXXXXX
Primary Care Physician Phone:	**Service Type:**
Service Date: MM/DD/YYYY	**Trace Number (Eligibility Verification Confirmation (EVC) Number:** OOOOOAKEOR

Share of Cost (SOC)

- Share of cost is a preset dollar amount that is determined by DHCS for an individual or for a family
  - This amount must be met each month before the member is eligible for Medi-Cal benefits
  - Any health care services, including non-covered services, may be used to meet SOC
- Only update SOC for services that are performed in your dental office
- Payment for the SOC is based on the provider office policy and the member

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

Case Numbers

- Case numbers indicate the member is part of a family SOC
- SOC Case Summary Report
  - Provided by the member's social worker or local county office
  - Indicates all family members involved
- Benefits may not be received by all in SOC
- No Eligibility Aid Codes:
  - IE – Ineligible
  - OO – No Aid Code
  - RR – Responsible Relative

250 Percent Working Disabled Program

- Members with aid code 6G
- The "Spend Down Obligation Amount" field is due to the 250 Percent Working Disabled Program, the message will state that the recipient is eligible for full-scope Medi-Cal
- The SOC amount is a premium that the recipient pays directly to the Department of Health Care Services (DHCS)
- Providers are not to collect SOC amounts from the Working Disabled Program recipients.
- www.dhcs.ca.gov/services/Pages/TPLRD_WD_cont.aspx

Updating Share of Cost thru the POS Network

EXAMPLE: Member share of cost is $87.00

Description	Date of Service	Procedure Code	UCR Fee	Member Portion
Examination	MM DD YY	D0150	$40.00	**$40.00**
2 Bitewings	MM DD YY	D0272	$27.00	**$27.00**
Prophy	MM DD YY	D1120	$60.00	**$20.00**
Total			**$127.00**	**$87.00**

THEN: Submit a claim to the Medi-Cal Dental program for all services provided.

Member Dental Cap

» $1800.00 Calendar year maximum
- Applies to adults only (21 years and over)
- Children are exempt (thru age 20)

» Exclusions to the Cap:
- Emergency dental services
- Dentures
- Maxillofacial and complex oral surgery
- Services provided for long-term care aid codes
- Services provided to residents of SNFs or ICFs
- Federally mandated services (including pregnancy-related services)

Cap has relaxed

Benefits Table Guide

Age / Aid Code	Full Scope Benefits	Section 4 Provider Handbook
Full Scope aid code ▪ Child (under 21) ▪ Adult (21 and over) ▪ Member resides in an ICF or SNF ▪ DDS Member	X	
Emergency/Pregnancy aid code ▪ All ages ▪ Member is NOT pregnant/postpartum		X
Member is pregnant/postpartum (regardless of age and aid code)	X	

Residents of Qualifying SNF, ICF, ICF-DD, ICF-DDH and ICF-DDN

» These members are eligible for additional services

» Services do not have to be provided in the facility to be payable

» All services provided in a SNF or ICF require prior authorization except for diagnostic services and emergency procedures

» Not all facilities qualify; therefore, use the website to confirm the classification and licensing of a facility:

https://www.cdph.ca.gov/programs/chcq/calhealthfind/Pages/Home.aspx

Pregnant Members

- Pregnant members, regardless of age, aid code and/or scope of benefits, are eligible to receive all dental procedures listed in the Manual Of Criteria (MOC)
- Includes 12 months of postpartum
- All requirements and criteria must be met
- Must document Pregnant or Postpartum

California Advancing and Innovation Medi-Cal: CalAIM

CalAIM: Overview

- CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal population by implementing a broad delivery system, and program and payment reform across the Medi-Cal program
- The major components of CalAIM were the successful outcomes of various pilots through the Dental Transformation Initiative (DTI)
- All FFS claims will be processed and paid in accordance with the Manual of Criteria (MOC) and the Schedule of Maximum Allowances (SMA)
- Effective January 1, 2022

CalAIM: Three Oral Health Initiatives

- Preventative Services: Pay for Performance (P4P)
- Caries Risk Assessment and Silver Diamine Fluoride Benefits
- Continuity of Care: Pay for Performance (P4P)

Preventative Services: Pay for Performance (P4P)

- P4P to increase statewide utilization of preventive services
- Performance payments will be included in the weekly check write for all qualified paid preventive services
- A performance payment at an additional 75% of the SMA
- SNC claims will need to be validated for qualifying codes prior to issuing payment
  - Performance payments are earned and paid to SNC locations once a month

PREVENTIVE SERVICES PAY FOR PERFORMANCE FEE SCHEDULE

PROCEDURE CODE	CODE DESCRIPTION	CURRENT SMA	PERFORMANCE PAYMENT	MEMBERS UNDER AGE 21	MEMBERS UNDER AGE 18	MEMBERS OVER 21
D1120	PROPHYLAXIS	$30.00	$22.50	X		
D1206	TOPICAL APPLICATION OF FLUORIDE – VARNISH (CHILD 0 TO 5)	$18.00	$13.50	X		
D1206	TOPICAL APPLICATION OF FLUORIDE – VARNISH (CHILD 6 TO 20)	$8.00	$6.00	X		
D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH (CHILD 0 TO 5)	18.00	$13.50	X		
D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH (CHILD 6 TO 20)	$8.00	$6.00	X		
D1351	SEALANT – PER TOOTH	$22.00	$16.50	X		
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT – PERMANENT TOOTH	$22.00	$16.50	X		
D1510	SPACE MAINTAINER – FIXED – UNILATERAL – PER QUADRANT	$120.00	$90.00		X	
D1516	SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY	$200.00	$150.00		X	
D1517	SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR	$200.00	$150.00		X	
D1526	SPACE MAINTAINER – REMOVABLE – BILATERAL, MAXILLARY	$230.00	$172.50		X	
D1527	SPACE MAINTAINER – REMOVABLE – BILATERAL, MANDIBULAR	$230.00	$172.50		X	
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY	$30.00	$22.50		X	
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR	$30.00	$22.50		X	
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT	$30.00	$22.50		X	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT	$30.00	$22.50	X		
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY	$30.00	$22.50	X		
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR	$30.00	$22.50	X		
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL – PER QUADRANT	$120.00	$90.00		X	
D1320	TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE	$10.00	$7.50			X
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT.	$46.00	$34.50			X

Caries Risk Assessment (CRA)

- CRA bundle includes the allowable increased frequencies for moderate and high-risk CRA bundles as a statewide dental benefit in alignment with national dental care standards
- To receive payment for the CRA bundle, dental providers must take the Treating Young Kids Everyday (TYKE) training hosted by the California Dental Association (CDA)
  - Providers will need to complete an attestation form and provide proof of TYKE training
  - Providers with an active status that have completed an attestation form and TYKE training during DTI domain 2 are not required to complete these again

Caries Risk Assessment (CRA) Bundle

- CRA bundles are based on the risk level associated with each Medi-Cal member, ages 0-6 only
- Bundle includes:
  - Caries Risk Assessment: D0601,D0602,D0603 ($15.00)
  - Nutritional counseling: D1310 ($46.00)
- Additional services such as cleaning, fluoride, and exam can be rendered based on the risk level

CalAIM Benefit: Caries Risk Assessment Bundles

	CARIES RISK ASSESSMENT ($15.00)	NUTRITIONAL COUNSELING ($46.00)	FREQUENCY	BUNDLE FEE
Low risk	D0601	D1310	6 months	$61.00
Moderate risk	D0602	D1310	4 months	$61.00
High Risk	D0603	D1310	3 months	$61.00

Silver Diamine Fluoride (SDF)

- SDF as a statewide dental benefit in alignment with the national dental care standards
- SDF is a covered service available for all ages
  - Subject to medical necessity
- Procedure code D1354 Interim Caries Arresting Medicament Application per tooth
  - The criteria must be met for payment
  - Paid $12.00 per tooth

CalAIM Benefit: D1354 Caries Arresting Medicament

- D1354 is a benefit once every 180 days, up to ten teeth per visit, for a maximum of four treatments per tooth, and requires a tooth code.
- For members under age 7 a photograph is required
  - Flexibilities allowed for members under age 4 (per SB 1403)
- Members age 7 or older:
  - Current intraoral photograph and
  - Current diagnostic periapical radiograph and
  - Must document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal

Continuity of Care: Pay for Performance (P4P)

- This P4P payment offers a flat rate payment to dental provider service office locations that maintain dental continuity of care by:
  - Performing at least a yearly dental exam/evaluation for two or more years in a row
- Paid at the flat rate of $55 once per year in addition to the SMA
  - Payment included in the weekly check write
- SNC claims will need to be validated for qualifying codes prior to issuing payment
  - Performance payments are earned and paid to SNC locations once a month

Continuity of Care: Example

Exam/evaluation paid for two or more consecutive years qualifies the service office location for a flat rate performance payment.

PAID EXAM/EVALUATION	CALENDAR YEAR 2022	CALENDAR YEAR 2023
D0120, D0145, D0150	X	X

Continuity of Care: Dental Codes

Service office locations are eligible to earn performance payments using any of the specified codes below:

» On one service performed annually

» At the flat rate of $55

PROCEDURE CODE	PROCEDURE CODE NAME
D0120	Periodic Oral Evaluation – Establish Patient
D0145	Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver
D0150	Comprehensive Oral Evaluation – New Or Established Patient

Resources and Forms for CalAIM

Department of Health Care Services CalAim Dental Initiative:
https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx

- Treating Young Kids Everyday (TYKE) training:
- Attestation form
- Caries Risk Assessment (CRA) form for Children

Questions about CalAIM?

- Email DHCS: dental@dhcs.ca.gov

Electronic Data Interchange

Electronic Data Interchange (EDI)

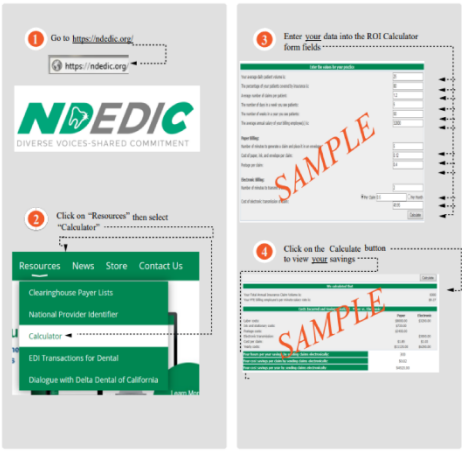
- EDI is the way that claims are submitted to Medi-Cal Dental electronically
- EDI claims are processed an average of five days faster than paper claims
- Over 70% of Medi-Cal Dental incoming documents are received electronically
- Claims, TARs, and NOAs can all be processed electronically

Benefits of Using EDI

- Maximize computer capabilities
- Make billing simpler
- Have fewer rejections
- Have tracking capabilities
- Receive payment faster
- Saves Money!

EDI Savings Calculator

- From the website: www.ndedic.org
- Click on the 'Resources' Tab and select the 'Calculator'
- Enter your data
- Click 'Calculate' to see your savings



Getting Started With EDI

- Must have practice management software or access to the internet
  - The practice management software may require you to enroll with a clearinghouse which works with their system
- Must enroll with the EDI department before submitting electronically
  - It takes 5-7 days for enrollment to process
  - Then you will be notified by phone and written correspondence
  - Read the EDI How to Guide!
- Do not send electronically until the office has been notified of activation by the Medi-Cal Dental program

When Preparing An EDI Document...

Complete	Complete required fields
Check	Check for accurate information
Use	Use the comment or note section of the software to provide additional written information
Use	Use only the current CDT procedure code format

Clearinghouse Daily Reports

Submitter Report

» This report is generated prior to the transmission of the claims to the clearinghouse

Transmission Summary Report

» This is verification that the claims have been received by the clearinghouse and have been submitted to the appropriate payers

Medi-Cal Dental Program EDI Reports

Daily EDI Documents Received Today CP-O-973-P

```
REPORT ID:    CP-O-973-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                     PAGE:        1
PROGRAM ID:    DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY

PROV/SVC    PROVIDER          BASE        RECIPIENT    NAME       SSN/CIN/
OR NPI      DCN               DCN         LAST         FIRST      OR MEDS
----------  ----------------  ----------  -----------  ---------  ---------
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    30.00
0000000000 O00000000          000000000 LAST           FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   200.00
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    55.00
0000000000 O00000000          YY000000000 LAST         FIRST      0000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    77.00
0000000000 O00000000          YY000000000 LAST         FIRST      0000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   331.00
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR:                  DOC TYPE: C   SUBMITTED FEE:  1430.00
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    30.00
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   100.00
0000000000 O00000000          YY000000000 LAST         FIRST      000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:    50.00
        TOTAL PROV/SVC OFC DOCUMENTS :     9
```

Documents Rejections CP-O-959-P

```
REPORT ID:     CP-O-959-P          MEDI-CAL DENTAL                  RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                     PAGE:  1
PROGRAM ID:    DCB969BS  ... DOCUMENT REJECTIONS ........

PROV/SVC      PROVIDER        RECIPIENT  NAME      D  SSN/CIN              RSN
 OR NPI         DCN           LAST       FIRST     T  OR MEDS    BASE DCN  CD
---------    ----------       ---------------     --------  - --------- --------
0000000000   000000000         LAST       FIRST       C                    A
0000000000   000000000         LAST       FIRST       C                    A
0000000000   000000000         LAST       FIRST       C                    G

   PROVIDER/SERVICE OFC TOTALS

   A - INVALID PROV/SVC OFC   :    2
   B - INVALID C/H            :    0
   C - INVALID PROV/CH        :    0
   D - BATCH REJECTED         :    0
   E - RECORD COUNTS MISMATCH :    0
   F - INVALID PROVIDER NAME  :    0
   G - DUPLICATE DOCUMENTS    :    1
   H - SECOND NOA ISSUED      :    0
   I - INVALID RETURN DCN     :    0
   J - SUB/PROV/SITE MISMATCH :    0
   K - CLM OVR 90 LINES - 4010:    0
   L - USE CIN OR BIC-NOT SSN :    0
   M - FILE VERSION NOT AUTH  :    0
   N - PDCN REQUIRED          :    0
   P - CLM OVR 50 LINES - 5010:    0

   TOTAL  REJECTIONS          :   3
```

The Binder System

» One way to manage the EDI reports is "The Binder System"

» In a standard three ring binder:

- Place index tabs numbered 1-31 (for the days of the month)
- File the Transmission or **CP-O-973-P** report under the date billed from the office

» This gives a starting point to track the EDI claims

The Binder System

» Indicate the date each claim is processed on the **CP-O-973-P** report

» Remove page once all claims are processed

```
    REPORT ID:      CP-O-973-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
    PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                        PAGE:        1
    PROGRAM ID:     DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY

•PROV/SVC    PROVIDER          BASE         RECIPIENT     NAME        SSN/CIN/
• OR NPI     DCN               DCN          LAST          FIRST       OR MEDS
•----------- ----------------- ------------ ------------- ----------- ----------
•0000000000 MCD141             YYXXXXXXXXX FIRST         NAME        000000000  MM/DD/YY
• MEDI CAL NBR: 00000000000000    DOC TYPE: C   SUBMITTED FEE:   117.00
•0000000000 Y0000000000000000 YYXXXXXXXXX FIRST         NAME        000000000  MM/DD/YY
• MEDI CAL NBR: 00000000000000    DOC TYPE: C   SUBMITTED FEE:    90.00
•0000000000 Y0000000000000000 YYXXXXXXXXX FIRST         NAME         000000000
• MEDI CAL NBR: 00000000000000    DOC TYPE: C   SUBMITTED FEE:   219.00
•0000000000 Y0000000000000000 YYXXXXXXXXX FIRST         NAME         000000000
• MEDI CAL NBR: 00000000000000    DOC TYPE: T   SUBMITTED FEE:    17.00


•    TOTAL PROV/SVC OFC DOCUMENTS :     4
```

Claims with Attachments

- For offices submitting documents through the mail:
  - Use the Base DCN listed on the report ID: **CP-O-971-P**
  - Mail radiographs to the Medi-Cal Dental program using special EDI labels and red-bordered envelopes
- For offices enrolled with a digitized imaging company, follow the format and instructions provided on sending:
  - Digitized images of radiographs/photos
  - Justification of Need (DC-054) forms
  - And narrative reports to the Medi-Cal Dental program

Digitized Images

- The digitized image number must be the 1st item in the comments/notes field
- Don't forget to include the '#' sign

  (NEA#999999/DTX#9999999/EHG#9999999/CHC#9999999)
- The date on the radiographs should match the "image created date"
  - The date the film/sensor was actually in the member's mouth

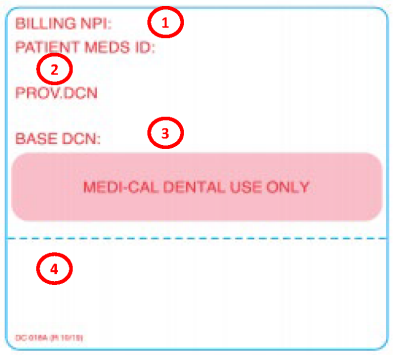
Digitized Images Not Successfully Submitted

- If radiographs or attachments are not successfully submitted using digitized imaging, the office will receive the X-Ray/Attachment Request Report, **CP-O-971-P**
- It will then be necessary to submit radiographs and attachments using the label process

Red EDI Labels

Labels must include:

1. Billing NPI
2. Member's first and last name below "PATIENT MEDS ID"
3. Base DCN
4. Provider's name and address



X-ray/Attachment Request CP-O-971-P

```
REPORT ID:     CP-O-971-P        MEDI-CAL DENTAL                RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                PAGE:        1
PROGRAM ID:    DCB971BS   X-RAY/ATTACHMENT REQUEST

  PROV/SVC   BASE         PROV              RECIPENT     NAME        SSN/CIN/
   OR NPI    DCN          DCN               LAST         FIRST       OR MEDS
---------- ---------- ------------------ ------------ ---------- ---------
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** TOTAL X-RAY/ATTACHMENT REQUESTS FOR PROV/SVC OFC.:      4
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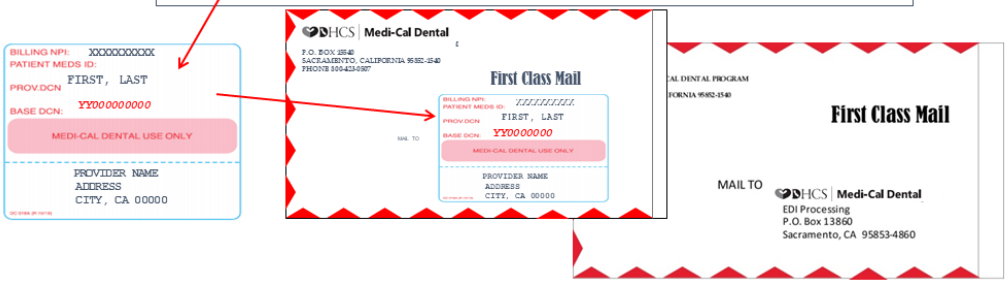

Daily EDI Documents Waiting Return CP-O-978-P

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PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                PAGE:        1
PROGRAM ID:    DCB978BS DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > 7 DAYS

PROV/SVC     ISSUE     DAYS    SSN/CIN/    MEDI-CAL       RECIPIENT    NAME    TYPE OF
OR NPI       DATE      SNCE    OR MEDS     NUMBER         LAST         FIRST   REQUEST
----------  --------  ----  ---------  --------------  ------------ ------  ---------
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PROV DCN: 00000000000       BASE DCN: YY0000000000 DOC TYPE: C SUB AMT:      30.00
0000000000   MM/DD/YY   24     000000000   00000000000000   LAST        FIRST   ADDIT DOC
PROV DCN: 00000000000       BASE DCN: YY0000000000 DOC TYPE: T SUB AMT:    1133.00
0000000000   MM/DD/YY   20     000000000   00000000000000   LAST        FIRST   ADDIT DOC
PROV DCN: 00000000000       BASE DCN: YY0000000000 DOC TYPE: T SUB AMT:    1486.00
0000000000   MM/DD/YY   17     000000000   00000000000000   LAST        FIRST   XRAY/ATTCH
PROV DCN: 00000000000       BASE DCN: YY0000000000 DOC TYPE: C SUB AMT:     100.00

        TOTAL PROV/SVC OFC DOCUMENTS :     4
```
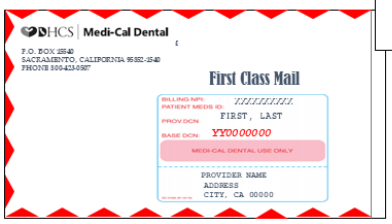

Example #1



Daily EDI Documents Waiting Return CP-O-978-P

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 PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                    PAGE:        1
 PROGRAM ID:    DCB978BS DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > 7 DAYS

 PROV/SVC     ISSUE     DAYS    SSN/CIN/    MEDI-CAL        RECIPIENT    NAME    TYPE OF
 OR NPI       DATE      SNCE    OR MEDS     NUMBER          LAST         FIRST   REQUEST
 ----------   --------  ----    ---------   --------------  -----------  ------  ----------
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 PROV DCN: 00000000000    BASE DCN: YY000000000 DOC TYPE: C SUB AMT:      30.00
 0000000000   MM/DD/YY   24     000000000   00000000000000    LAST         FIRST   ADDIT DOC
 PROV DCN: 00000000000    BASE DCN: YY000000000 DOC TYPE: T SUB AMT:    1133.00
 0000000000   MM/DD/YY   20     000000000   00000000000000    LAST         FIRST   ADDIT DOC
 PROV DCN: 00000000000    BASE DCN: YY000000000 DOC TYPE: T SUB AMT:    1486.00
 0000000000   MM/DD/YY   17     000000000   00000000000000    LAST         FIRST   XRAY/ATTCH
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                TOTAL PROV/SVC OFC DOCUMENTS :     4
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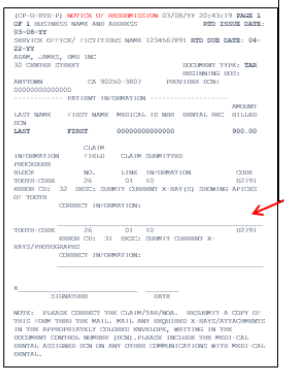
Example #2

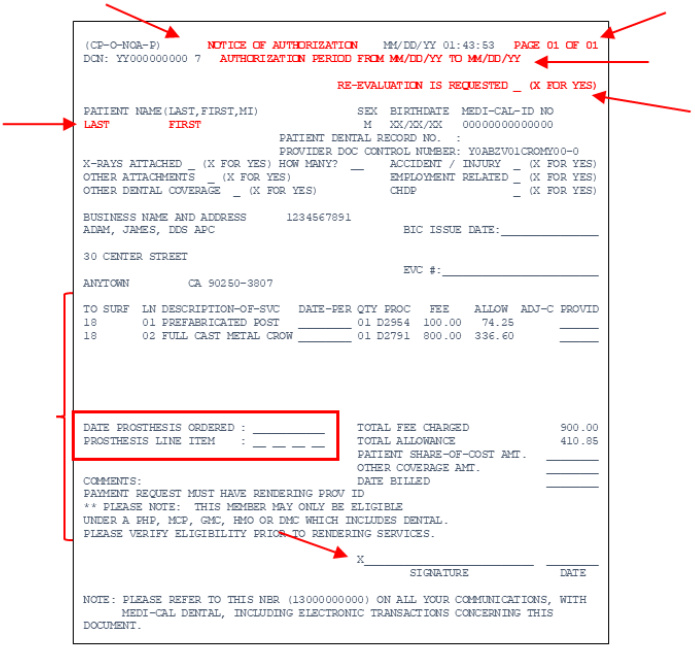


Notice of Resubmission CP-O-RTD-P

» RTD = Resubmission Turnaround Document

```
(CP-O-RTD-P)    NOTICE OF RESUBMISSION          MM/DD/YY 20:43:19 PAGE  01 OF 01
BUSINESS NAME AND ADDRESS                              RTD ISSUE DATE: MM/DD/YY
SERVICE OFFICE/ FICTITIOUS NAME          1234567891    RTD DUE DATE: MM/DD/YY
ADAM, JAMES, DMD INC

30 CENTER STREET                                  DOCUMENT TYPE: TAR
                                                  BEGINNING DOS:
ANYTOWN          CA 90250-3807                    PROVIDER DCN : 000000000000000
------------PATIENT INFORMATION --------------------
                                                          AMOUNT
LAST NAME    FIRST NAME  MEDICAL ID NBR  DENTAL REC       BILLED      DCN
LAST         FIRST       00000000000000                   900.00      YY000000000 7

                CLAIM
INFORMATION     FIELD    CLAIM SUBMITTED            PROCEDURE
BLOCK           NO.      LINE  INFORMATION          CODE
TOOTH-CODE      26        01   10                   D2791
          ERROR CD:  32  DESC: SUBMIT CURRENT X-RAY(S) SHOWING APICES OF TOOTH
          CORRECT INFORMATION:

TOOTH-CODE      26        01   10                   D2791
          ERROR CD:  31  DESC: SUBMIT CURRENT X-RAYS/PHOTOGRAPHS
          CORRECT INFORMATION:

X_____________________________  _______
        SIGNATURE                DATE

NOTE:  PLEASE CORRECT THE CLAIM/TAR/NOA.  RESUBMIT A COPY OF THIS FORM THRU THE
MAIL.  MAIL ANY REQUIRED X-RAYS/ATTACHMENTS IN THE APPROPRIATELY COLORED ENVELOPE,
WRITING IN THE DOCUMENT CONTROL NUMBER (DCN).  PLEASE INCLUDE THE MEDI-CAL DENTAL
ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH MEDI-CAL DENTAL.
```

Notice of Authorization (NOA) CP-O-NOA-P



(CP-O-NOA-P) NOTICE OF AUTHORIZATION MM/DD/YY 01:43:53 PAGE 01 OF 01
DCN: YY000000000 7 AUTHORIZATION PERIOD FROM MM/DD/YY TO MM/DD/YY

RE-EVALUATION IS REQUESTED _ (X FOR YES)

PATIENT NAME(LAST,FIRST,MI) SEX BIRTHDATE MEDI-CAL-ID NO
LAST FIRST M XX/XX/XX 00000000000000
PATIENT DENTAL RECORD NO. :
PROVIDER DOC CONTROL NUMBER: Y0ABZV01CROMY00-0
X-RAYS ATTACHED _ (X FOR YES) HOW MANY? __ ACCIDENT / INJURY _ (X FOR YES)
OTHER ATTACHMENTS _ (X FOR YES) EMPLOYMENT RELATED _ (X FOR YES)
OTHER DENTAL COVERAGE _ (X FOR YES) CHDP _ (X FOR YES)

BUSINESS NAME AND ADDRESS 1234567891
ADAM, JAMES, DDS APC BIC ISSUE DATE:_____

30 CENTER STREET
EVC #:_____
ANYTOWN CA 90250-3807

TO SURF	LN	DESCRIPTION-OF-SVC	DATE-PER	QTY	PROC	FEE	ALLOW	ADJ-C	PROVID
18	01	PREFABRICATED POST	_____	01	D2954	100.00	74.25		
18	02	FULL CAST METAL CROW	_____	01	D2791	800.00	336.60		

DATE PROSTHESIS ORDERED : _____
PROSTHESIS LINE ITEM : __ __ __ __

TOTAL FEE CHARGED 900.00
TOTAL ALLOWANCE 410.85
PATIENT SHARE-OF-COST AMT. _____
OTHER COVERAGE AMT. _____
DATE BILLED _____

COMMENTS:
PAYMENT REQUEST MUST HAVE RENDERING PROV ID
** PLEASE NOTE: THIS MEMBER MAY ONLY BE ELIGIBLE
UNDER A PHP, MCP, GMC, HMO OR DMC WHICH INCLUDES DENTAL.
PLEASE VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICES.

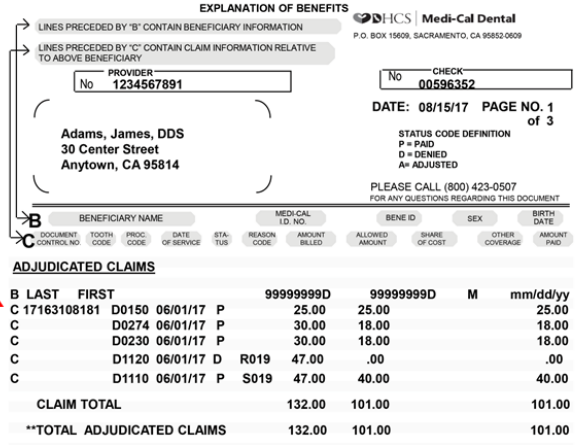
X_____ _____
SIGNATURE DATE

NOTE: PLEASE REFER TO THIS NBR (13000000000) ON ALL YOUR COMMUNICATIONS, WITH MEDI-CAL DENTAL, INCLUDING ELECTRONIC TRANSACTIONS CONCERNING THIS DOCUMENT.

Identify EDI Claims on an EOB

All EDI Document Control Numbers (Base DCN) have a 6, 8, or 9 as the 7th digit.

- Example: YY00918XXXX



EXPLANATION OF BENEFITS

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION
LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

DHCS | Medi-Cal Dental
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER No 1234567891
CHECK No 00596352
DATE: 08/15/17 PAGE NO. 1 of 3

Adams, James, DDS
30 Center Street
Anytown, CA 95814

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO | TOOTH CODE | PROC CODE | DATE OF SERVICE | STATUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

ADJUDICATED CLAIMS

B	LAST	FIRST				99999999D	99999999D	M	mm/dd/yy
C	17163108181	D0150	06/01/17	P		25.00	25.00		25.00
C		D0274	06/01/17	P		30.00	18.00		18.00
C		D0230	06/01/17	P		30.00	18.00		18.00
C		D1120	06/01/17	D	R019	47.00	.00		.00
C		D1110	06/01/17	P	S019	47.00	40.00		40.00
	CLAIM TOTAL					132.00	101.00		101.00
	**TOTAL ADJUDICATED CLAIMS					132.00	101.00		101.00

EDI Support

For additional EDI information and support please contact:

- 800-423-0507
- medi-caldentaledi@gainwelltechnologies.com

Claims Processing Flow Chart

Enrollment

- Enrolls providers into program

Input Prep

- Receives forms from provider
- Sorts by document type
- Assigns control numbers
- Scans documents and attachments

Data Correction

- Corrects/verifies input data
- Forwards input documents to appropriate data control center (DCC) for further action as directed by the system

File Maintenance

- Restores discrepancies between database file information and input data
- Forwards resolved documents to appropriate DCC as directed by the system

Claims Adjudication

- Paraprofessional and professional staff adjudicate via PC using radiographs, scanned documents and attachments
- Forwards documents to appropriate DCC

System Batch Adjudication

- Updates nightly records and stores data processed from that day
- Transfers claim/TAR information into recipient's history file
- Collects payment data for weekly check run
- Generates reports
- Generates NOAs, RTDs, CIRs to provider

Document Control

- Stores processed document hard copies according to specific time frames
- Files and retains documents awaiting RTD response
- Maintains files
- Forwards x-ray envelopes to Recycle or Outgoing Mail for return to provider

Outgoing Mail

- Uses Phillipsburg equipment when appropriate to fold documents, stuff envelopes and affix postage
- Meters x-ray envelopes

Customer Support

- Communicates with providers via telephone and written correspondence
- Researches and responds to provider inquiries
- Handles provider enrollment and training

Provider Forms

Provider Forms: TAR/Claim, NOA, RTD, EOB

- Use only these Medi-Cal Dental forms to bill or send prior authorization to the program
- All forms and envelopes are free of charge
  - Re-order through the program's form supplier
- Best Practices:
  - Do Not: make copies, puncture holes, or use stamp signatures
  - Do: use only live signatures and make sure alignment is correct

Contact the Customer Service Center 800-423-0507 for a reprint of a document.

Radiographs and Photographs

- Radiographs and photographs will not be returned to providers
  - Send only duplicate x-rays or paper copies
- They must be single sided
- Nothing on the back
- Make sure it is clear and legible
- Staple to the appropriate claim or authorization on the top left-hand corner

In administering California Medi-Cal Dental, the primary function is to process Claims and Treatment Authorization Requests (TARs) submitted by providers for dental services performed for Medi-Cal members. It is the intent of the Medi-Cal Dental program to process documents as quickly and efficiently as possible.

Only Medi-Cal Dental specific, State-approved forms are accepted by Medi-Cal Dental. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Medi-Cal dental covered services. An introductory packet of billing forms is mailed to all newly enrolled providers so they may begin participating in the Medi-Cal Dental program. All billing forms are available from the Medi-Cal Dental forms supplier at no charge to providers.

The Provider Handbook Section 6 (Forms) contains detailed, step-by-step instructions for completing each of the Medi-Cal Dental forms. The handbook also provides a handy Do and Do Not list to help complete treatment forms accurately.

All incoming documents are received and sorted by Gainwell Technology. Claims and TARs are separated from other incoming documents and correspondence, and then assigned a Document Control Number (DCN). The DCN is a unique 11-digit number that identifies the treatment form throughout the processing system. By using the DCN, the Medi-Cal Dental program can answer inquiries concerning the status of any treatment form received.

DCN = Document Control Number
CRN = Correspondence Reference Number

YY	091	1	12345
Year	Julian Date	Document Identifier	Sequential Number

Document Identifier Code	
1. Claim/TAR	5. Written Correspondence
2. RTD	6. Enrollment Forms
3. CIF	7. Telephone Inquiry
4. MC177	8. NOA

The Treatment Authorization Request (Tar)/Claim Form

The TAR/Claim form is used to request authorization of proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Medi-Cal Dental. If there is more than one dentist or dental hygienist alternative practice (RDHAP) at a service office billing under a single dentist's provider number, enter the NPI of the dentist or RDHAP who performed the service.

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed. To submit the TAR/Claim form to the Medi-Cal Dental program, follow these steps:

1. Check the form for completeness. Sign and date the form where appropriate.
2. Use two separate forms when requesting payment for dated services and prior authorization of treatment for other services. This will expedite reimbursement of allowable procedures.
3. When using forms DC-202 or DC-209, detach page 2 "yellow page" and retain for the patient's record. If using form DC-217, print an additional laser copy for the patient's record.
4. If required, include necessary copies or duplicate radiographs/photos by stapling them to the corresponding form. More information may be found in Section 6: Forms, of the Handbook.
5. Mail the completed form(s) in the large pre-addressed mailing envelope (DC-206) that is provided to you free of charge. Up to 10 forms with attachments may be mailed in a single document mailing envelope.
6. Mail the TAR/Claim forms to:

   Medi-Cal Dental
   P.O. Box 15610
   Sacramento, CA 95852-0610

Treatment Authorization Request (TAR) Sample

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm / dd / yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address	00000	

9. CHECK IF RADIOGRAPHS ATTACHED?	YES	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF	YES
HOW MANY? 9		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE:	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES X	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.)	20. BILLING PROVIDER NPI
Adams, James DDS	1234567891
21. MAILING ADDRESS	**TELEPHONE NUMBER**
30 Center Street	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
Anytown, CA	95814

BIC Issue Date: _____

EVC #: _____

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH/QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
U		1 Partial Denture – Resin Base			D5211	400.00	
L		2 Partial Denture – Resin Base			D5212	400.00	
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

All other treatment has been completed
See attached DC-054 form

35. TOTAL FEE CHARGED	800.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	MM DD YY

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

X Mary Smith
SIGNATURE

MM DD YY
DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

Claim Form Sample

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm / dd / yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address	00000	

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY? 3	YES X	11. CHECK IF ACCIDENT/INJURY? / EMPLOYMENT RELATED?	YES / YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
				14. MEDICARE DENTAL COVERAGE:	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.)	20. BILLING PROVIDER NPI
ADAMS, JAMES DDS	1234567891
21. MAILING ADDRESS	**TELEPHONE NUMBER**
30 CENTER STREET	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
ANYTOWN, CA	95814

BIC Issue Date: mm/dd/yy

EVC #: 123456789A1

22. PLACE OF SERVICE: X (OFFICE 1 | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL INPATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8)

EXAMINATION AND TREATMENT

26. TOOTH/ARCH/QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Exam	MM DD YY		D0150	25.00	9912345678
		2 4 Bitewings	MM DD YY		D0274	20.00	9912345678
		3 Additional PA's	MM DD YY	6	D0230	24.00	9912345678
8	MIF	4 Composite	MM DD YY		D2332	150.00	9912345678
5	MOD	5 Amalgam	MM DD YY		D2160	65.00	9912345678
16		6 Extraction	MM DD YY		D7140	125.00	9912345678
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED	409.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	MM DD YY

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

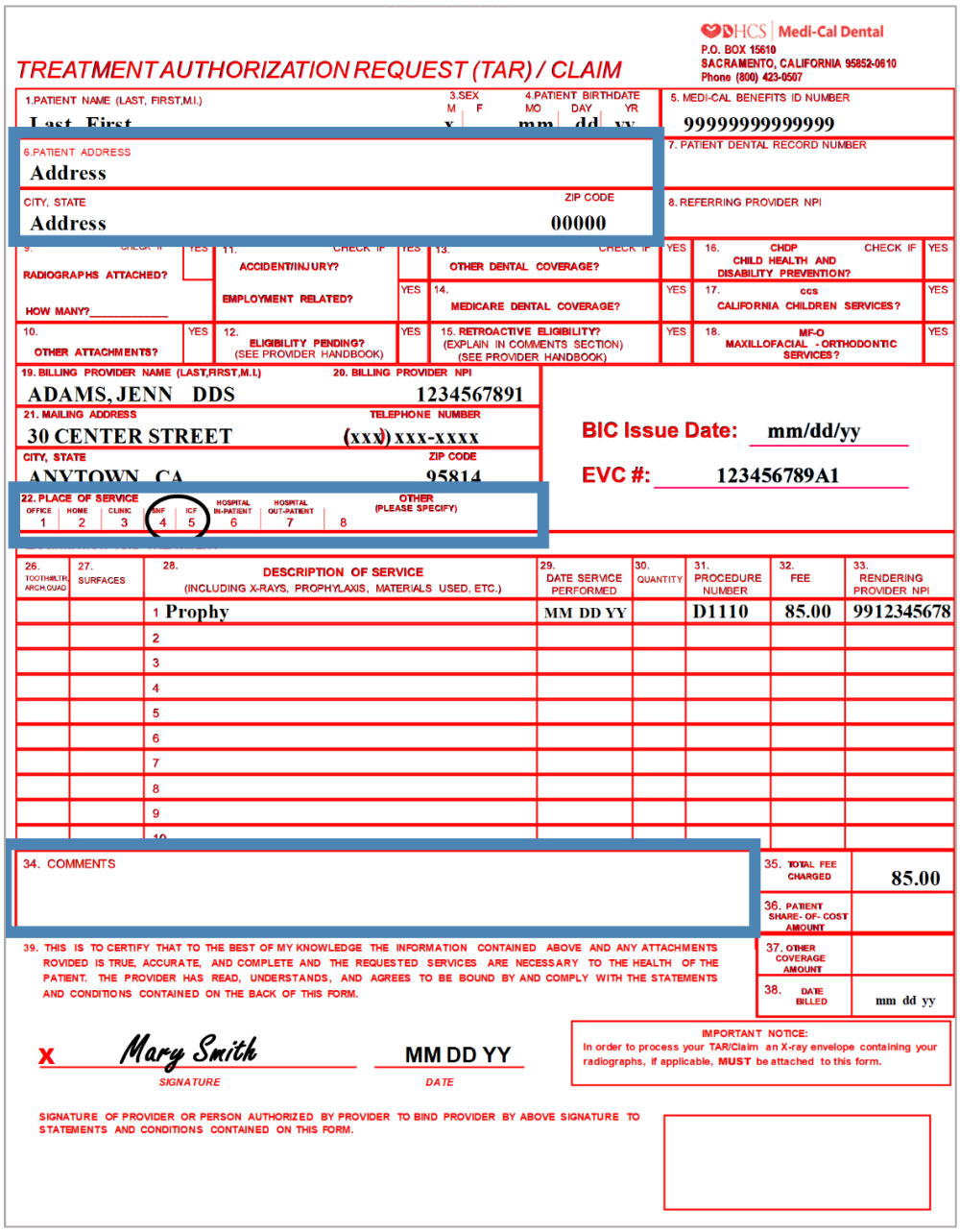
IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

X _____ _____
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

Example of a Facility Claim Form



DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

1.PATIENT NAME (LAST, FIRST,M.I.): Last First | 3.SEX: M F: x | 4.PATIENT BIRTHDATE: MO mm DAY dd YR yy | 5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999

6.PATIENT ADDRESS: Address | 7. PATIENT DENTAL RECORD NUMBER

CITY, STATE: Address | ZIP CODE: 00000 | 8. REFERRING PROVIDER NPI

9. RADIOGRAPHS ATTACHED? HOW MANY?_____ YES
11. ACCIDENT/INJURY? EMPLOYMENT RELATED? CHECK IF YES
13. OTHER DENTAL COVERAGE? YES
16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
14. MEDICARE DENTAL COVERAGE? YES
17. CCS CALIFORNIA CHILDREN SERVICES? YES
10. OTHER ATTACHMENTS? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.): ADAMS, JENN DDS | 20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 CENTER STREET | TELEPHONE NUMBER: (xxx) xxx-xxxx
CITY, STATE: ANYTOWN CA | ZIP CODE: 95814

BIC Issue Date: mm/dd/yy
EVC #: 123456789A1

22. PLACE OF SERVICE: OFFICE 1 | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

26. TOOTH/MLTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Prophy	MM DD YY		D1110	85.00	9912345678
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED: 85.00
36. PATIENT SHARE- OF- COST AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED: mm dd yy

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS ROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, MUST be attached to this form.

X Mary Smith — SIGNATURE | MM DD YY — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

When the patient resides in a qualifying facility, the following information is required:

Box 6: Member address = Facility's address

Box 22: Check #4 or #5 regardless of where the member is being treated

Box 34: Comment Box:

- Facility name and phone number
- If treating patients outside of the facility, indicate in box 34 where the patient is actually being treated, i.e., office, hospital

TAR/Claim Form Helpful Hints and Reminders

1. Use only the Current CDT procedure codes. Be sure to use all four digits including the leading “D”.
2. Use the quantity column (Field 30) when listing multiple procedures with the same procedure number.
3. When submitting the form for payment of dated services, be sure to include the rendering provider number in Field 33.
4. Sign and date the form.
5. Staple any necessary attachments (e.g., operative reports, DC-054 Forms and/or copies of radiographs/photos, etc.) to the back of the form with one staple in the upper right or left corner.
6. Continuous TAR/Claim forms and laser forms are not pre-imprinted by the Medi-Cal Dental program. Enter the provider's name, number, and address exactly as it appears on your initial stock of forms.
7. If dated services are submitted on a request for authorization, they will not be paid until the authorized services are paid.
8. Medi-Cal Dental's evaluation of TARs and Claims will be more accurate when narrative documentation is included. Use Field 34 for any narrative documentation.
    a. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
    b. Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form
    c. If submitting electronically, abbreviate comments to make optimum use of allotted space.

Billing Limitations

The Medi-Cal Dental program will consider payment for dated services based on the Schedule of Maximum Allowance (SMA) if the form is received:

Payment % of SMA	Time Frame
100%	Within 6 months of the date of service
75%	Within 7 to 9 months of the date of service
50%	Within 10 to 12 months of the date of service
0	After 12 months from the date of service

» Payment is ALWAYS subject to member eligibility

The Notice of Authorization (NOA) Form

The NOA is a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization. The Medi-Cal Dental program will indicate on the NOA whether the requested services are allowed, modified, or disallowed. Subsequently, the NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

The NOA will be pre-printed by the Medi-Cal Dental program with the following information:

- Authorization period (the 'From' and 'To' date)
- Member information
- Provider information
- Procedures allowed, modified, and/or disallowed
- Allowance
- Adjudication Reason Codes (A list of adjudication codes may be found in section 7 of the Provider Handbook)

NOTE*: Prior to completing the form, verify the information printed is correct.*

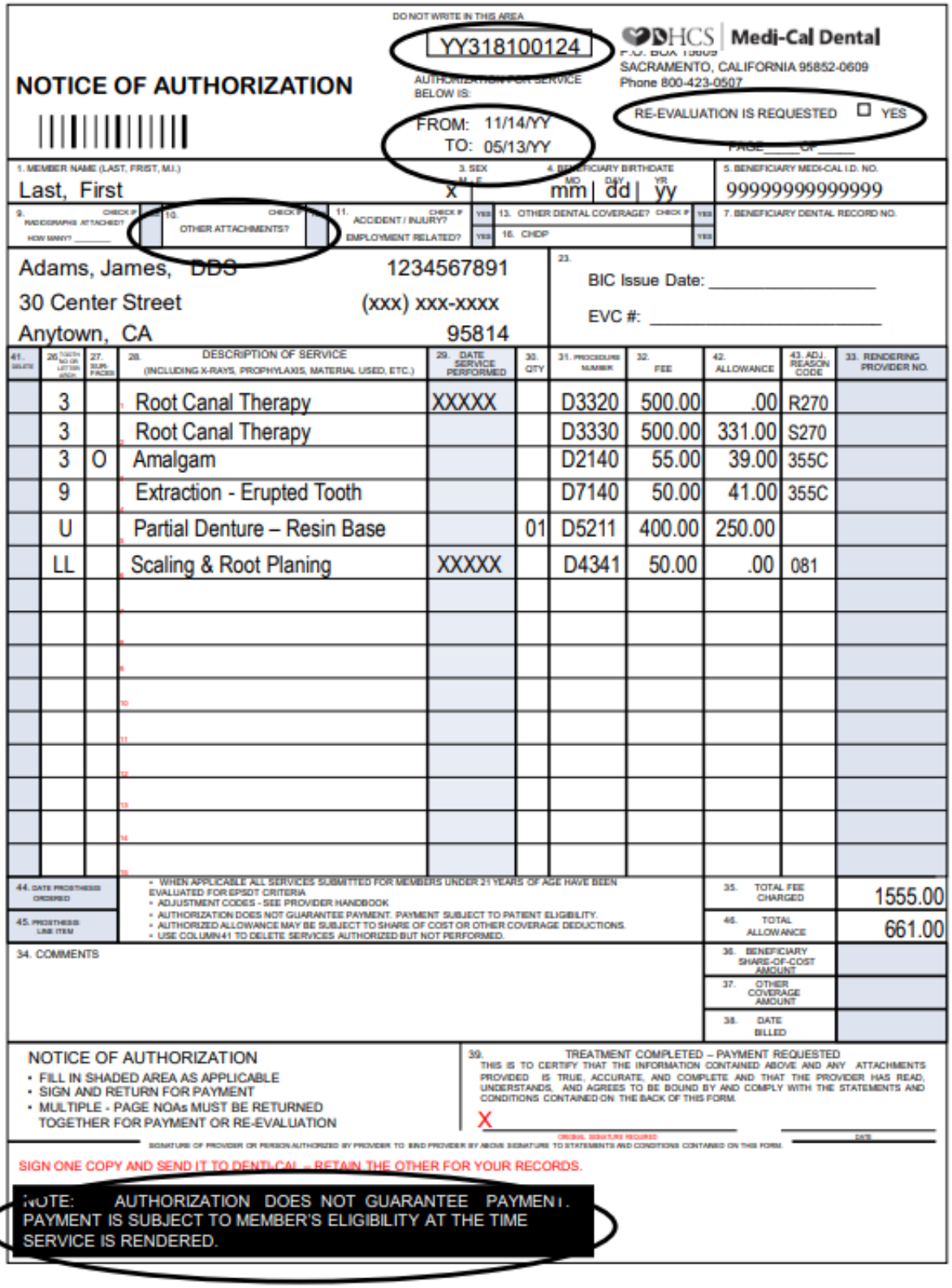
The NOA has a statement printed on the bottom of the form that reads: “NOTE: Authorization does not guarantee payment. Payment subject to member's eligibility.” This statement has been added to remind providers to verify the member's eligibility prior to providing services.

Authorizations are valid for 180 days. Once the services have been performed, complete the appropriate shaded areas on the NOA, sign and date, and submit one copy to the Medi-Cal Dental program for payment. Retain the other copy for the patient's record.

Services not requiring prior authorization may be added to the NOA. However, any required radiographs and/or documentation for those procedures must be included.

The Medi-Cal Dental program will consider payment of 100% of the Schedule of Maximum Allowances (SMA), for services rendered if the NOA form is received within six months of the FINAL date of service. If the NOA is received within seven to nine months of the FINAL date of service, 75% of the SMA will be considered for payment. And, if the NOA is received within ten to twelve months of the FINAL date of service, 50% of the SMA will be considered for payment.

Notice of Authorization (NOA) Sample



DO NOT WRITE IN THIS AREA

YY318100124

DHCS | Medi-Cal Dental

P.O. BOX 13609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/YY
TO: 05/13/YY

RE-EVALUATION IS REQUESTED ☐ YES

PAGE ____ OF ____

1. MEMBER NAME (LAST, FIRST, M.I.)	3. SEX M F	4. BENEFICIARY BIRTHDATE MO DAY YR	5. BENEFICIARY MEDI-CAL I.D. NO.
Last, First	X	mm dd yy	99999999999999

9. RADIOGRAPHS ATTACHED? CHECK IF YES HOW MANY? ____	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? EMPLOYMENT RELATED? CHECK IF YES	13. OTHER DENTAL COVERAGE? CHECK IF YES	7. BENEFICIARY DENTAL RECORD NO.
			16. CHDP YES	

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23. BIC Issue Date: _____
EVC #: _____

41. DELETE	26. TOOTH NO OR LETTER IF PRIM.	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
	3		1 Root Canal Therapy	XXXXX		D3320	500.00	.00	R270	
	3		2 Root Canal Therapy			D3330	500.00	331.00	S270	
	3	O	3 Amalgam			D2140	55.00	39.00	355C	
	9		4 Extraction - Erupted Tooth			D7140	50.00	41.00	355C	
	U		5 Partial Denture – Resin Base		01	D5211	400.00	250.00		
	LL		6 Scaling & Root Planing	XXXXX		D4341	50.00	.00	081	
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- WHEN APPLICABLE, ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA
- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	1555.00
40. TOTAL ALLOWANCE	661.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION
- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. TREATMENT COMPLETED – PAYMENT REQUESTED
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ _____
ORIGINAL SIGNATURE REQUIRED — DATE
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SIGN ONE COPY AND SEND IT TO DENTI-CAL – RETAIN THE OTHER FOR YOUR RECORDS.

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO MEMBER'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

NOA Reevaluation Request

Reevaluation of a modified or denied treatment plan may be requested. The reevaluation request must be received by the Medi-Cal Dental program on or prior to the expiration date. To request reevaluation, follow these steps:

1. Check the box marked “REEVALUATION REQUESTED” in the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include new or additional documentation and enclose radiographs, as necessary.
4. Return the NOA to:

   Medi-Cal Dental

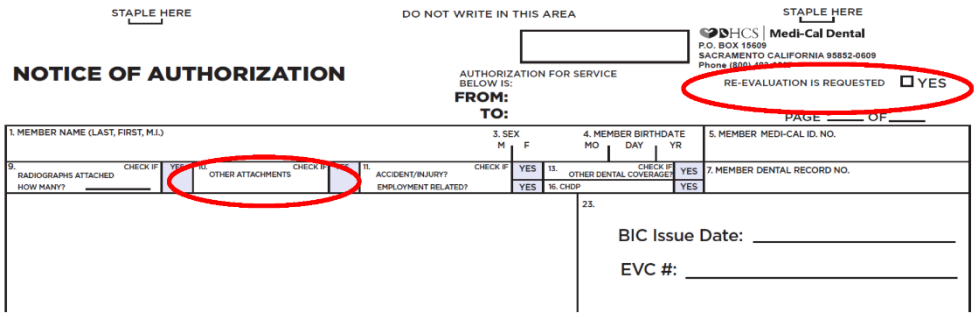
   P.O. Box 15609

   Sacramento, CA 95852-0609

5. After reevaluation, a new NOA will be sent to your office.

If a denial is upheld and another review is wanted, a new TAR must be submitted.

Re-evaluation Request



- Do Not sign NOA
- Do submit radiographs and new / additional documentation
- NOA must be received on or before the expiration date
- NOA may only be resubmitted 1 time

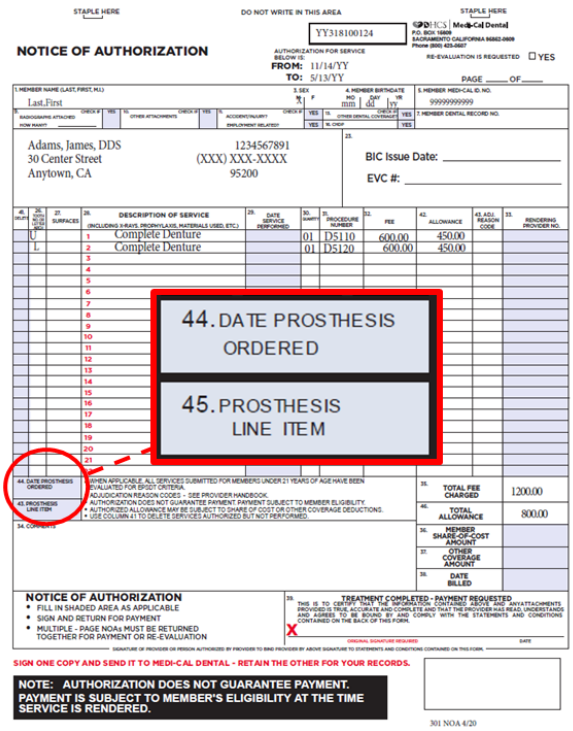
NOA Helpful Hints and Reminders

1. Providers must wait until the NOA is received from the Medi-Cal Dental program before providing services that require prior authorization.
2. Do not attach a CIF when requesting a reevaluation.
3. Return all upper pages of a multi-page NOA at the same time.
4. Include the rendering provider number in Field 33 of the NOA.
5. Sign and date the NOA when submitting for payment.

NOTE: *Authorization does not guarantee payment. Payment is subject to a member's eligibility. Refer to the Provider Handbook Section 6 (Forms) for more information.*

NOA Hints and Reminders

- Altered Treatment Plan
- Lab Order Date
- Undeliverable Appliance
- Billing Limitations



Resubmission Turnaround Document (RTD)

An RTD is a computer-generated form used by Medi-Cal Dental to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The RTD is divided into two sections: Section “A” and Section “B”.

Section “A” notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section “A” is assigned a letter of the alphabet under “field.” Section “A” is kept by the provider for office records. Section “A” also indicates the return due date. The provider has 45 days to respond to the RTD.

Section “B” is the corrected information filled in by the provider. This section is returned to Medi-Cal Dental.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

To ensure the RTD is properly processed, follow these steps:

1. Sign and date the RTD. If the RTD is returned unsigned, the requested information cannot be used to process the original claim, TAR or NOA.
2. Return all pages of a multi-page RTD in one envelope.
3. Return the RTD promptly. If the RTD is not received by the Medi-Cal Dental program, within the 45-day time limitation, the Medi-Cal Dental program must deny the original claim, TAR or NOA.
4. Return the RTD to:

   Medi-Cal Dental
   PO Box 15609
   Sacramento, CA 95852-0609

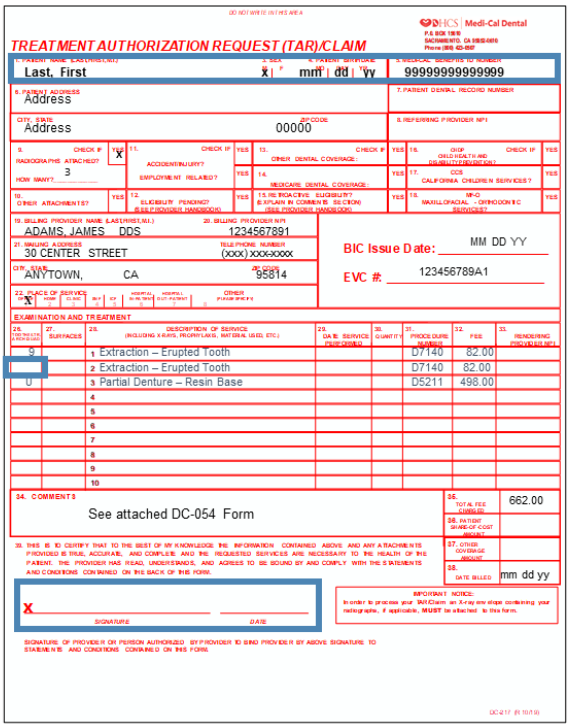
Upon receipt of the RTD, Medi-Cal Dental matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

NOTE: *If the RTD is not returned within the 45-day time limitation, the TAR, Claim or NOA will be denied according to Medi-Cal Dental policies.*

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

» Example of why an RTD might be sent to your office:

- Mismatched member information
- Missing tooth code
- Missing live signature



DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 13616
SACRAMENTO, CA 95813-4616
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,MI) Last, First | 2. SEX x | F | 4. PATIENT BIRTHDATE mm | dd | yy | 5. MEDI-CAL BENEFITS ID NUMBER 99999999999999

6. PATIENT ADDRESS Address | 7. PATIENT DENTAL RECORD NUMBER

CITY, STATE Address | ZIP CODE 00000 | 8. REFERRING PROVIDER NPI

8. CHECK IF RADIOGRAPHS ATTACHED? YES x — HOW MANY? 3 | 11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED? YES | 13. CHECK IF OTHER DENTAL COVERAGE: YES | 16. CHDP CHILD HEALTH AND DISABILITY PREVENTION PROGRAM? YES

14. MEDICARE DENTAL COVERAGE: YES | 17. CCS CALIFORNIA CHILDREN SERVICES? YES

10. OTHER ATTACHMENTS? YES | 12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES | 15. NO INCENTIVE SUBSIDY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES | 18. MP-O MAXILLOFACIAL - ORTHODONTIC PROVIDER? YES

19. BILLING PROVIDER NAME (LAST,FIRST,MI.) ADAMS, JAMES DDS | 20. BILLING PROVIDER NPI 1234567891

21. MAILING ADDRESS 30 CENTER STREET | TELEPHONE NUMBER (xxx) xxx-xxxx

CITY, STATE ANYTOWN, CA | ZIP 95814

BIC Issue Date: MM DD YY

EVC #: 123456789A1

22. PLACE OF SERVICE: x HOME | CLINIC | SKF | ICF | HOSPITAL (IN PATIENT) | HOSPITAL (OUT-PATIENT) | OTHER (PLEASE SPECIFY)

EXAMINATION AND TREATMENT

26. TOOTH NUMBER (IF APPLICABLE)	27. SURFACES	25. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
9		1 Extraction – Erupted Tooth			D7140	82.00	
		2 Extraction – Erupted Tooth			D7140	82.00	
0		3 Partial Denture – Resin Base			D5211	498.00	
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS: See attached DC-054 Form

35. TOTAL FEE CHARGED: 662.00

36. PATIENT SHARE OF COST AMOUNT:

37. OTHER COVERAGE AMOUNT:

38. DATE BILLED: mm dd yy

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

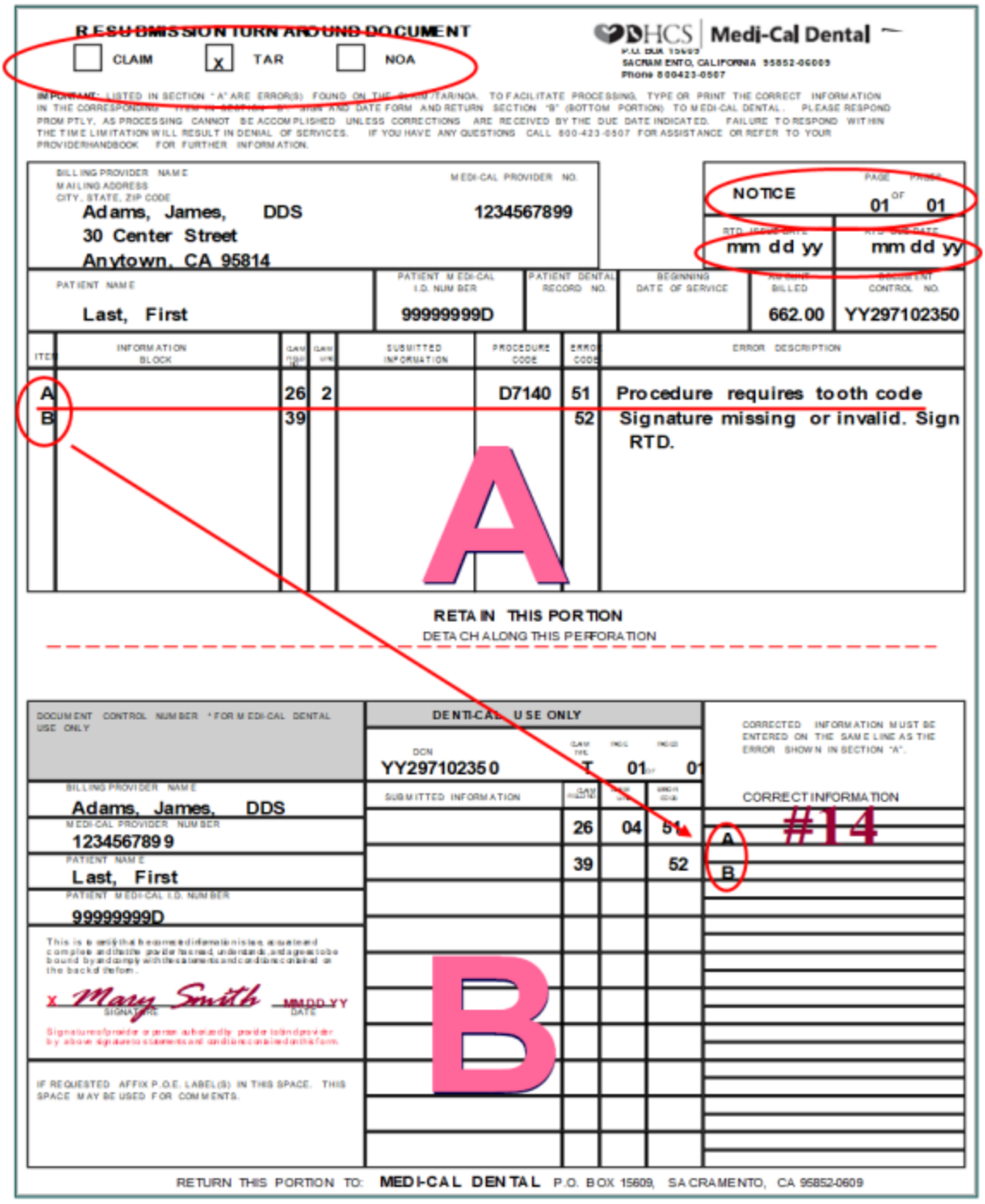
x _____ SIGNATURE _____ DATE

IMPORTANT NOTICE: In order to process your TAR/Claim an X-ray and chart containing your radiographs, if applicable, MUST be attached to this form.

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO SIGN PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/10)

Resubmission Turnaround Document Sample



RESUBMISSION TURN AROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

DHCS | Medi-Cal Dental

P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-06009
Phone 800423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO MEDI-CAL DENTAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDERHANDBOOK FOR FURTHER INFORMATION.

BILLING PROVIDER NAME
MAILING ADDRESS
CITY, STATE, ZIP CODE
Adams, James, DDS
30 Center Street
Anytown, CA 95814

MEDI-CAL PROVIDER NO.
1234567899

NOTICE
PAGE 01 OF 01

RTD mm dd yy

PATIENT NAME: Last, First
PATIENT MEDI-CAL I.D. NUMBER: 99999999D
PATIENT DENTAL RECORD NO.
BEGINNING DATE OF SERVICE
AMOUNT BILLED: 662.00
DOCUMENT CONTROL NO.: YY297102350

ITEM	INFORMATION BLOCK	CLAIM TYPE	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		26	2		D7140	51	Procedure requires tooth code
B		39				52	Signature missing or invalid. Sign RTD.

A

RETAIN THIS PORTION
DETACH ALONG THIS PERFORATION

DOCUMENT CONTROL NUMBER * FOR MEDI-CAL DENTAL USE ONLY

DENTI-CAL USE ONLY
DCN: YY2971023500
CLAIM TYPE: T
PAGE: 01 OF 01

BILLING PROVIDER NAME: Adams, James, DDS
MEDI-CAL PROVIDER NUMBER: 1234567899
PATIENT NAME: Last, First
PATIENT MEDI-CAL I.D. NUMBER: 99999999D

This is to certify that the named dentist is an active and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of the form.

X Mary Smith MMDDYY
SIGNATURE DATE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.

SUBMITTED INFORMATION	DATE PAGE	DATE LINE	ERROR CODE
	26	04	51
	39		52

B

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

CORRECT INFORMATION

#14

A
B

RETURN THIS PORTION TO: MEDI-CAL DENTAL P.O. BOX 15609, SACRAMENTO, CA 95852-0609

Explanation of Benefits (EOB)

The EOB is a computer-generated statement that accompanies each Medi-Cal Dental payment. It lists all paid, modified and denied claims which have been processed during the payment cycle, as well as adjusted claims, and claims and TARs which have remained “in process” for more than 18 days. The EOB also shows non-claims-specified information, such as payable/receivable amounts, and levy deductions. EOBs are normally issued weekly.

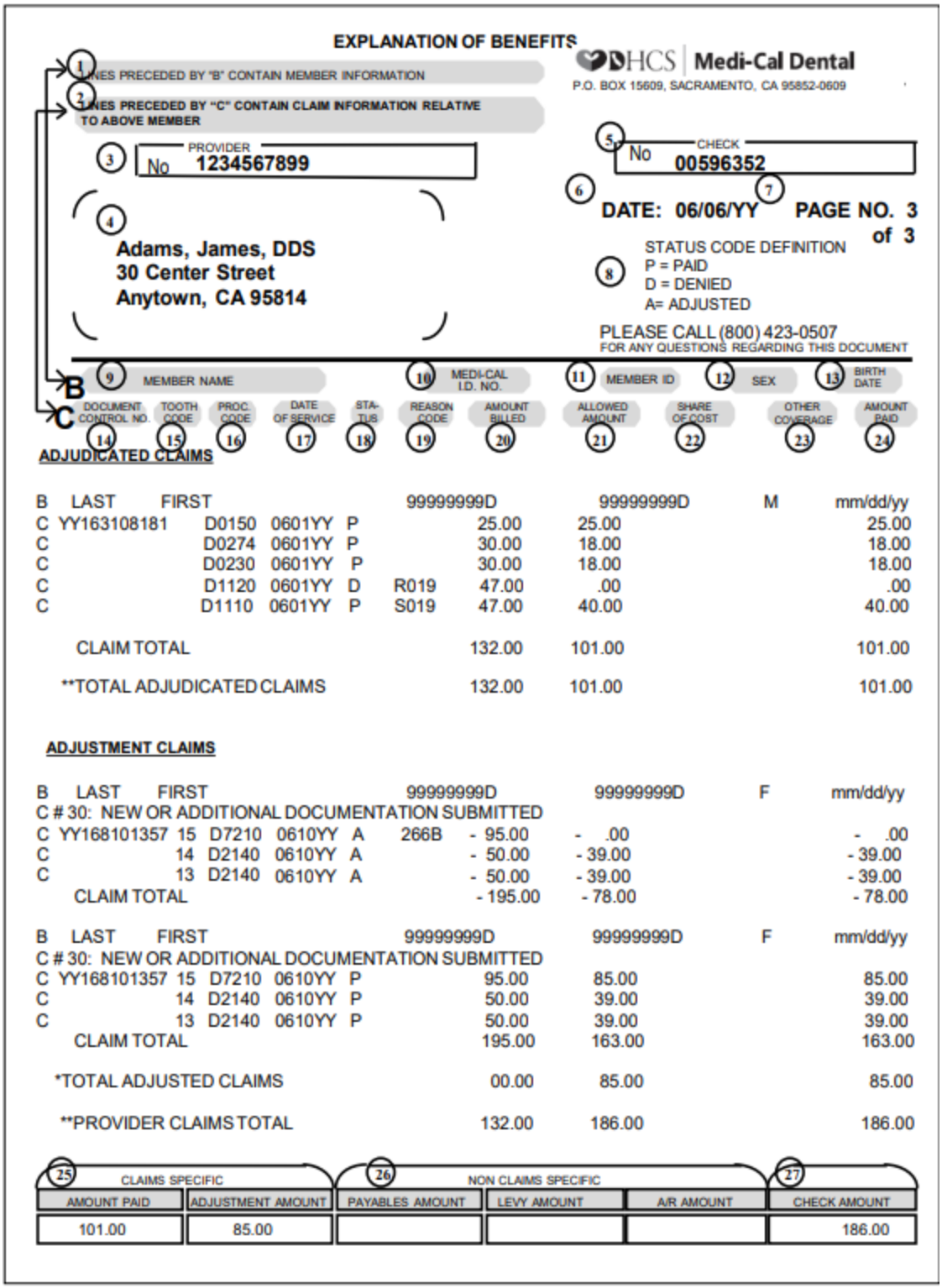
Following is an explanation of each item shown on the sample EOB:

1. **The member information:** This line is preceded by an “B” for member information.
2. **Claim information for the listed member:** This line is preceded by a “C” for “Claim”.
3. **Provider Number:** The National Provider Identifier (NPI) number that was issued by NPPES to a provider for their type of business.
4. **Provider Name and Address:** The provider’s name and billing address.
5. **Check Number:** The number of the check issued with the EOB.
6. **Date:** The date the EOB was issued.
7. **Page Number:** The page number(s) of the EOB.
8. **Status Code Definition:** The list of each status code used to identify a claim line and explanation of what each code means.
9. **Member Name:** The name of the member; last name, first name and middle initial. Each member is listed individually.
10. **Medi-Cal ID Number:** The number issued to the member by Medi-Cal and shown on the BIC (only the first nine digits will appear on the EOB).
11. **Member ID:** The member’s ID number.
12. **Sex:** The sex of the member.
13. **Birth Date:** The member’s date of birth.
14. **Document Control Number:** The identifying number assigned to each claim received by the Medi-Cal Dental program.
15. **Tooth Code:** The tooth number or letter, arch code or quadrant listed to help identify the procedure(s) reported on the EOB.
16. **Procedure Code:** The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.

17. **Date of Service:** The date the service was performed.
18. **Status:** Identifies the status of each claim line. (See item 8 for a list of status codes and their definitions.)
19. **Reason Code:** Explains why a claim line was either denied, modified, altered, or paid at an amount other than billed. The reason codes and a written explanation of each one are printed on the EOB.
20. **Amount Billed:** The amount billed for each claim line.
21. **Allowed Amount:** The amount allowed by the Medi-Cal Dental program for each claim line. This amount is the lesser of the billed amount and maximum amount allowed by the Schedule of Maximum Allowances (SMA).
22. **Share of Cost:** The amount the member paid toward a Share of Cost.
23. **Other Coverage:** The amount paid by Medicare or any other insurance carrier.
24. **Amount Paid:** The total amount paid to a provider after any applicable deductions shown in item 22 and 23.
25. **Claims Specific:** The total amounts of all paid and adjusted claims listed on the EOB.
26. **Non-Claims Specific:** The total payable amounts, levy amounts and receivable amounts listed on the EOB, if applicable. This information is printed on the last page of the EOB.
27. **Check Amount:** The amount of the check that accompanies the EOB.

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

Explanation of Benefits (EOB) Sample



EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

1 LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION
2 LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

3 PROVIDER No 1234567899

5 CHECK No 00596352

6 DATE: 06/06/YY 7 PAGE NO. 3 of 3

4
Adams, James, DDS
30 Center Street
Anytown, CA 95814

8 STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B 9 MEMBER NAME 10 MEDI-CAL I.D. NO. 11 MEMBER ID 12 SEX 13 BIRTH DATE

C DOCUMENT CONTROL NO. 14 | TOOTH CODE 15 | PROC. CODE 16 | DATE OF SERVICE 17 | STA-TUS 18 | REASON CODE 19 | AMOUNT BILLED 20 | ALLOWED AMOUNT 21 | SHARE OF COST 22 | OTHER COVERAGE 23 | AMOUNT PAID 24

ADJUDICATED CLAIMS

B	LAST	FIRST				99999999D		99999999D		M	mm/dd/yy
C	YY163108181		D0150	0601YY	P		25.00	25.00			25.00
C			D0274	0601YY	P		30.00	18.00			18.00
C			D0230	0601YY	P		30.00	18.00			18.00
C			D1120	0601YY	D	R019	47.00	.00			.00
C			D1110	0601YY	P	S019	47.00	40.00			40.00
	CLAIM TOTAL						132.00	101.00			101.00
	**TOTAL ADJUDICATED CLAIMS						132.00	101.00			101.00

ADJUSTMENT CLAIMS

B	LAST	FIRST				99999999D		99999999D		F	mm/dd/yy
C	# 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY168101357	15	D7210	0610YY	A	266B	- 95.00	- .00			- .00
C		14	D2140	0610YY	A		- 50.00	- 39.00			- 39.00
C		13	D2140	0610YY	A		- 50.00	- 39.00			- 39.00
	CLAIM TOTAL						- 195.00	- 78.00			- 78.00
B	LAST	FIRST				99999999D		99999999D		F	mm/dd/yy
C	# 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY168101357	15	D7210	0610YY	P		95.00	85.00			85.00
C		14	D2140	0610YY	P		50.00	39.00			39.00
C		13	D2140	0610YY	P		50.00	39.00			39.00
	CLAIM TOTAL						195.00	163.00			163.00
	*TOTAL ADJUSTED CLAIMS						00.00	85.00			85.00
	**PROVIDER CLAIMS TOTAL						132.00	186.00			186.00

25 CLAIMS SPECIFIC		26 NON CLAIMS SPECIFIC			27
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00				186.00

EOB Documents in Process Sample

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "R" CONTAIN MEMBER INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER
No 1234567899

CHECK
No 00596352

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 06/06/YY PAGE NO. 3 of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B MEMBER NAME | MEDI-CAL I.D. NO. | MEMBER ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

DOCUMENTS IN-PROCESS

LAST NAME	FIRST NAME	MEDI-CAL ID	MEMBER ID	DOB	DCN	AMT BILLED	*CODE	
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY168108150	567.00	C	IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY169103850	423.00	T	CS
LAST	FIRST	99999999A	99999999A	mm/dd/yy	YY175100684	112.00	C	IR

TOTAL DOCUMENTSIN-PROCESS 3 TOTAL BILLED 1102.00

* THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR REEVALUATION

DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR XRAYS/ATTACHMENTS WAS SENT TO PROVIDER)
RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

++

THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:30 AM TO 11:30 AM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

++

THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

++

THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:30 AM TO 3:30 PM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

Claim Inquiry Forms (CIF)

Submitting a Claim Inquiry Form (CIF) enables the Medi-Cal Dental program to give an automated, fast response to an inquiry. The dental office should use the CIF for two reasons:

1. Inquire about the status of a TAR or Claim
    a. The Medi-Cal Dental program will respond to a CIF with a Claim Inquiry Response (CIR).
2. Request reevaluation of a modified or denied claim or NOA for payment.

CIF Tracer

A CIF tracer is used to request the status of a TAR or claim. Providers should wait one month before submitting a CIF Tracer to allow enough time for the document to be processed. If after one month, the claim or TAR has not been processed or has not appeared in the “Documents In-Process” section of the Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Reevaluation

A CIF claim re-evaluation is used to request the reevaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the “Adjusted Claims” section.

Claim re-evaluations must be received within 6 months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

To submit a CIF to Medi-Cal Dental, follow these steps:

1. Use a separate CIF for each inquiry.
2. Check only one inquiry reason box on each CIF.
3. Complete all applicable areas.
4. Sign and date.
5. Attach all related radiographs/photos.
6. Do not use the CIF to request a first level appeal.

7. Mail to:

   Medi-Cal Dental
   PO Box 15609
   Sacramento, CA 95852-0609

Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Customer Service Center at (800) 423-0507

All radiographs/photos submitted with a CIF must be stapled to the back of the corresponding CIF.

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

Claim Inquiry Response (CIR)

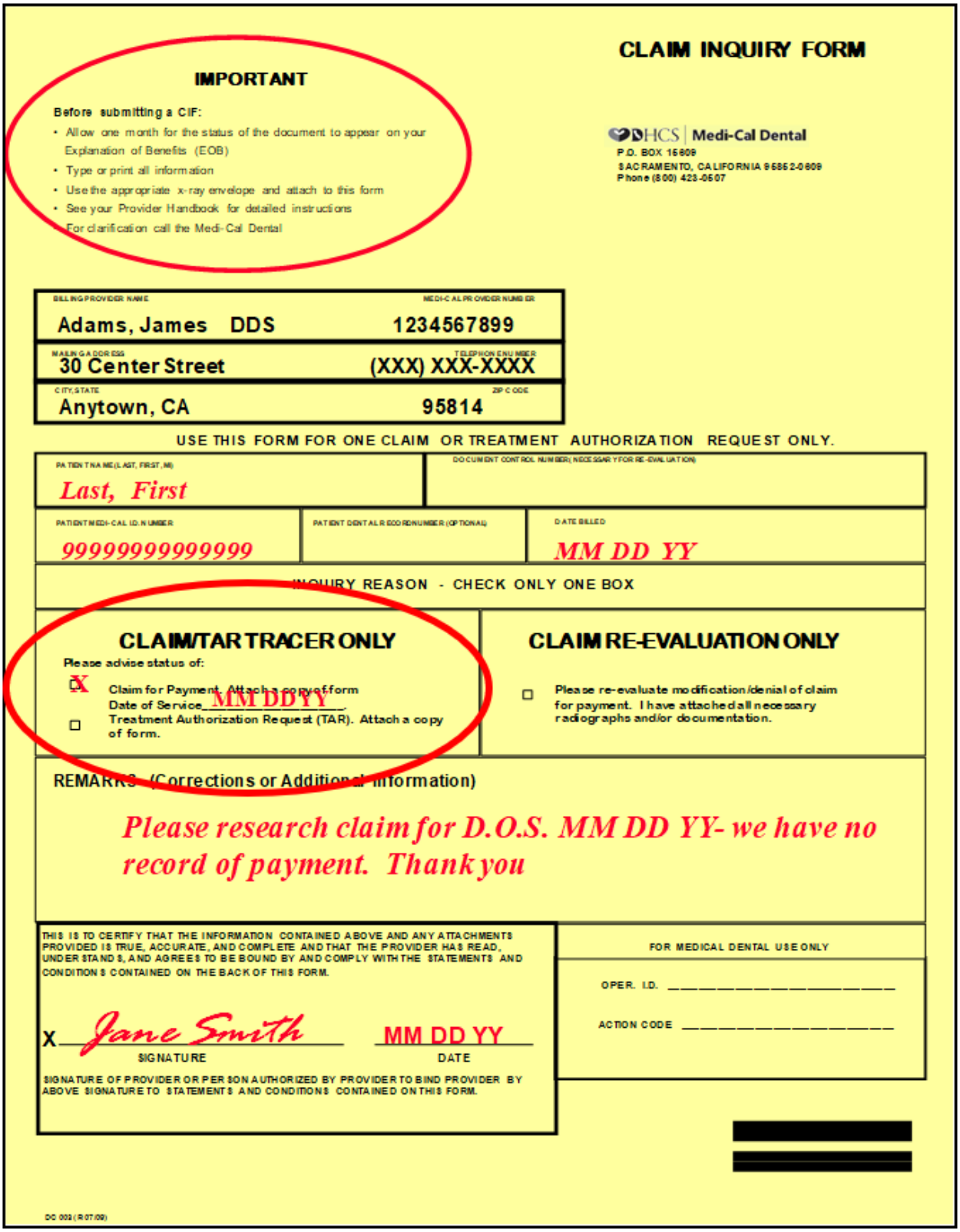
Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Medi-Cal Dental will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- Member name
- Member Medi-Cal identification number
- Member Dental Record or account number, if applicable
- Document Control Number of the original document
- The date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY" will contain a status code and a typed explanation of that code. Refer to the Provider Handbook Section 7 (Codes) for more information.

Claim Inquiry Form – Tracer Sample



CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions

For clarification call the Medi-Cal Dental

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone (800) 423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James DDS	1234567899
MAILING ADDRESS: 30 Center Street	TELEPHONE NUMBER: (XXX) XXX-XXXX
CITY, STATE: Anytown, CA	ZIP CODE: 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI)	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
Last, First	

PATIENT MEDI-CAL ID. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
99999999999999		*MM DD YY*

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

☒ Claim for Payment. Attach a copy of form
Date of Service *MM DD YY*.

☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

☐ Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional Information)

Please research claim for D.O.S. MM DD YY- we have no record of payment. Thank you

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X *Jane Smith* (SIGNATURE) *MM DD YY* (DATE)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR MEDICAL DENTAL USE ONLY

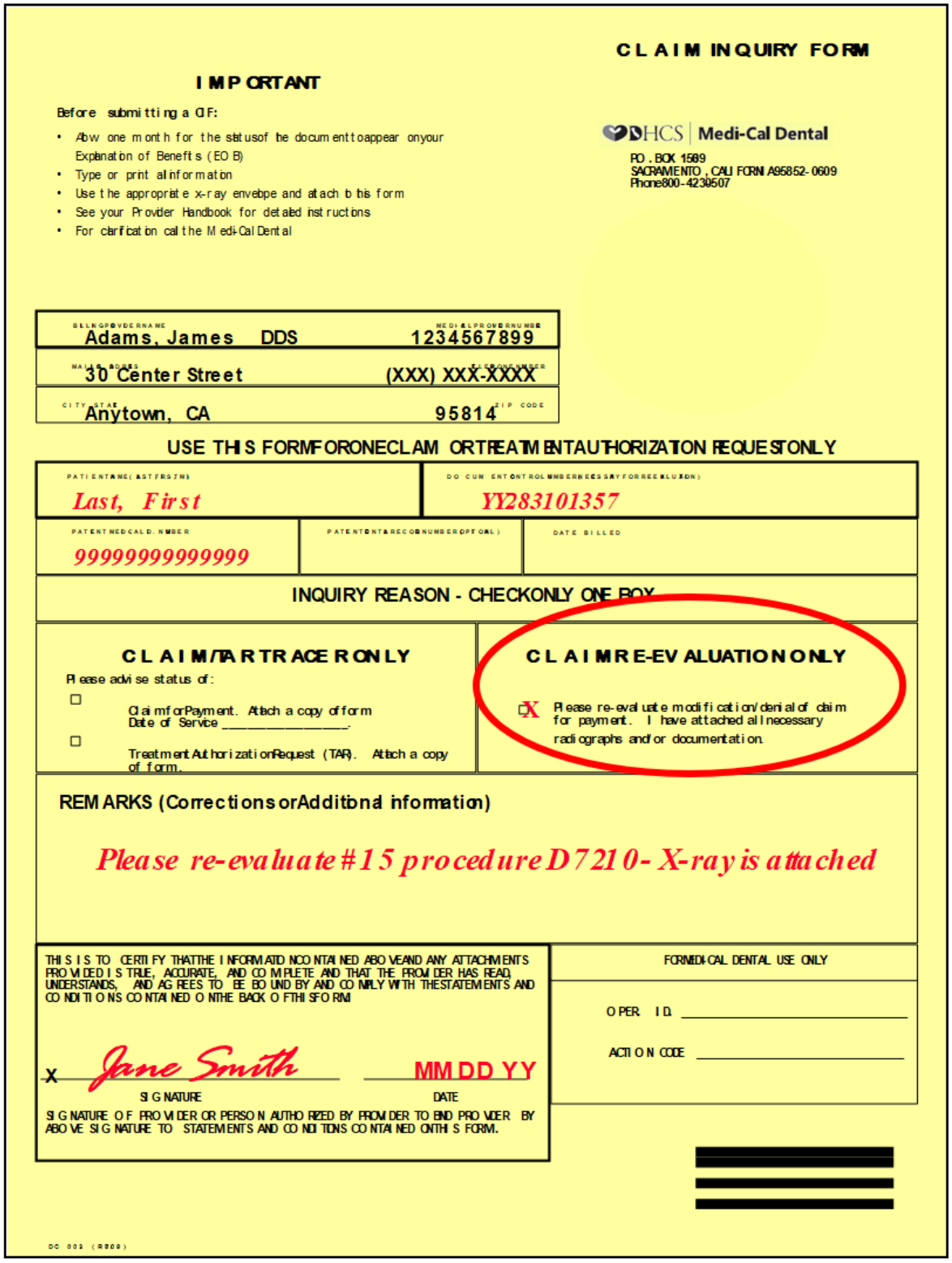
OPER. I.D. _____

ACTION CODE _____

[redacted]

DC 003 (R 07/09)

Claim Inquiry Form – Reevaluation Sample



CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call the Medi-Cal Dental

DHCS | Medi-Cal Dental
PO. BOX 1589
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME: Adams, James DDS
MEDI-CAL PROVIDER NUMBER: 1234567899
MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: (XXX) XXX-XXXX
CITY STATE: Anytown, CA
ZIP CODE: 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY

PATIENT NAME (LAST FIRST MI): Last, First
DOCUMENT CONTROL NUMBER (IF NECESSARY FOR CORRELATION): YY283101357
PATIENT MEDICAID NUMBER: 99999999999999
PATIENT CHART RECORD NUMBER (OPTIONAL):
DATE BILLED:

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

☐ Claim for Payment. Attach a copy of form Date of Service _____.

☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

☒ Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional information)

Please re-evaluate #15 procedure D7210 - X-ray is attached

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X Jane Smith
SIGNATURE

MM DD YY
DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR MEDI-CAL DENTAL USE ONLY

OPER ID: _____

ACTION CODE: _____

DC 002 (R808)

Claim Inquiry Response Sample

CORRESPONDENCE REFERENCE NUMBER * FOR MEDI-CAL DENTAL USE ONLY

YY30900132

CLAIM INQUIRY RESPONSE

Adams, James, DDS
30 Center Street
Anytown, CA

1234567899
(XXX) XXX-XXXX
95814

DHCS | Medi-Cal Dental
P.O.BOX 15609
SACRAMENTO, CALIFORNIA 95852
Phone (800) 423-0507

PATIENT NAME	DOCUMENT CONTROL NO.	
Last, First		
PATIENT MEDI-CAL I.D. NO.	PATIENT DENTAL RECORD NUMBER	DATE BILLED
99999999D		MM DD YY

IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY

STATUS CODE	EXPLANATION
01	CLAIM NEVER RECEIVED: PLEASE SUBMIT NEW CLAIM

ADDITIONAL EXPLANATION

BY: 7AW DATE: MM DD YY

The Provider Appeals Process

First Level Appeals

- Submit appeal within 90 days:
  - Use letterhead not a CIF
  - Letter must specifically request a 1st Level Appeal
  - Send all information/copies to uphold the request
  - Send Appeals directly to the Appeals address
  - Office will receive written notification from the Medi-Cal Dental program within 21 days
- Last recourse with the Medi-Cal Dental Program

First Level Appeals

A provider may request a First Level Appeal by submitting a formal written grievance to the Medi-Cal Dental program. Submission of a CIF is not required prior to the First Level Appeal.

The First Level Appeal procedure is as follows:

1. The provider must submit the appeal by letter to Medi-Cal Dental within 90 days of the EOB denial date. Do not use CIFs for this purpose.
2. The letter must specifically request a first-level appeal.
3. Send all information and copies to justify the request. Include all documentation and radiographs.
4. The appeal should clearly identify the claim or TAR involved and describe the disputed action.
5. First-level appeals should be directed to:

   Medi-Cal Dental
   Attn: Provider First-Level Appeals
   PO Box 13898
   Sacramento, CA 95853-4898

The Medi-Cal Dental staff (including professional review if necessary) will review the appeal and respond in writing if the denial is upheld.

The provider should keep copies of all documents related to the first-level appeal.

Judicial Remedy

Under Title 22 regulations, a Medi-Cal Dental provider who is dissatisfied with the first-level appeal decision may then use the judicial process to resolve the complaint. In compliance with Section 14104.5 of the Welfare and Institutions Code, the provider must “seek judicial remedy” no later than one year after receiving notice of the decision of the First Level Appeal.

EOB Adjustment Claims Sample

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER No **1234567899**

CHECK No **00596352**

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 06/06/YY PAGE NO. 1 of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

	MEMBER NAME	MEDI-CAL I.D. NO.	MEMBER ID	SEX	BIRTH DATE
B					

C	DOCUMENT CONTROL NO	TOOTH CODE	PROC CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID
ADJUSTMENT CLAIMS											
B	LAST	FIRST					99999999D	99999999D	F		mm/dd/yy
C	#30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY283101357	15	D7210	1010YY	A	266B	- 95.00	- .00			- .00
C		14	D2140	1010YY	A		- 50.00	- 39.00			- 39.00
C		13	D2140	1010YY	A		- 50.00	- 39.00			- 39.00
	CLAIM TOTAL						-195.00	- 78.00			- 78.00
B	LAST	FIRST					99999999D	99999999D	F		mm/dd/yy
C	#30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY283101357	15	D7210	1010YY	P		95.00	85.00			85.00
C		14	D2140	1010YY	P		50.00	39.00			39.00
C		13	D2140	1010YY	P		50.00	39.00			39.00
	CLAIM TOTAL						195.00	163.00			163.00
	*TOTAL ADJUSTED CLAIMS						.00	85.00			85.00
	**PROVIDER CLAIMS TOTAL						132.00	186.00			186.00

ADJUDICATED CLAIM REASON CODE DESCRIPTIONS

WHEN APPLICABLE, ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA.

266B PAYMENT AND/OR PRIOR AUTHORIZATION DISALLOWED. LACK OF RADIOGRAPHS

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	**85.00**				**186.00**

Glossary

Billing Provider: The dentist who bills or requests authorization for services on the treatment form.

Treatment Authorization Request (TAR)/Claim: The State approved universal form used by the provider to request prior authorization of services, and/or the form submitted by the provider to request payment for services performed.

Claim Inquiry Form (CIF): The form used by the provider for tracing a claim or TAR, or for requesting a reevaluation or adjustment to a previously submitted claim.

Correspondence Reference Number (CRN): An identifying number assigned to all telephone correspondence, written correspondence and CIF's received by the Medi Cal Dental program.

Medi-Cal Dental: The Fee-for-Service portion of the California Medi-Cal Dental Program.

Medi-Cal Dental Bulletin: A publication with information regarding program updates, pertinent legislative action, procedure clarifications, and other important items which affect the California Medi-Cal Dental Program. The bulletins may be accessed from the Medi-Cal Dental website.

Medi-Cal Dental Provider Handbook: A reference guide for all providers enrolled in the California Medi-Cal Dental Program. It contains the criteria for dental services, program benefits, exclusions, limitations, and instructions for completing forms used in the Medi-Cal Dental program. The Handbook may be accessed from the Medi-Cal Dental website.

Document Control Number (DCN): An identifying number assigned to all billing documents received by the Medi Cal Dental program. The DCN enables the Medi-Cal Dental to track the document throughout the automated processing system.

Notice Of Authorization (NOA): A computer-generated form sent to the provider following final processing of a TAR by the Medi-Cal Dental program. When the NOA is returned to the Medi-Cal Dental by the provider, it becomes a claim submitted for payment of services rendered.

Provider: Individual dentists, dental group, dental school, or dental clinic.

Resubmission Turnaround Document (RTD): A computer-generated form which the Medi-Cal Dental program sends to the provider to request missing or additional information needed to complete processing of a claim, TAR or NOA.

Rendering Provider: The dentist who provides services that are billed under the billing provider's name and billing provider number. The rendering provider may be the same as, or different from the billing provider.