California
Medi-Cal Dental

Orthodontic Seminar Packet

Revised 05/09/2024

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

Dear Medi-Cal Dental Provider and Staff:

Welcome! We have prepared this packet especially for orthodontists and their staff who attend our provider training seminar for the Orthodontic Services Program under California Medi-Cal Dental.

The material contained in this packet is designed to familiarize you with the Medi-Cal Dental orthodontic program utilizing the CDT 23 procedure codes, policies, procedures, and billing requirements. For further information, please refer to the Provider Handbook located on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

We appreciate your interest in California Medi-Cal Dental and hope you will benefit from the information presented at today's seminar. If you have any questions, please call our toll-free number, (800) 423-0507.

Sincerely,

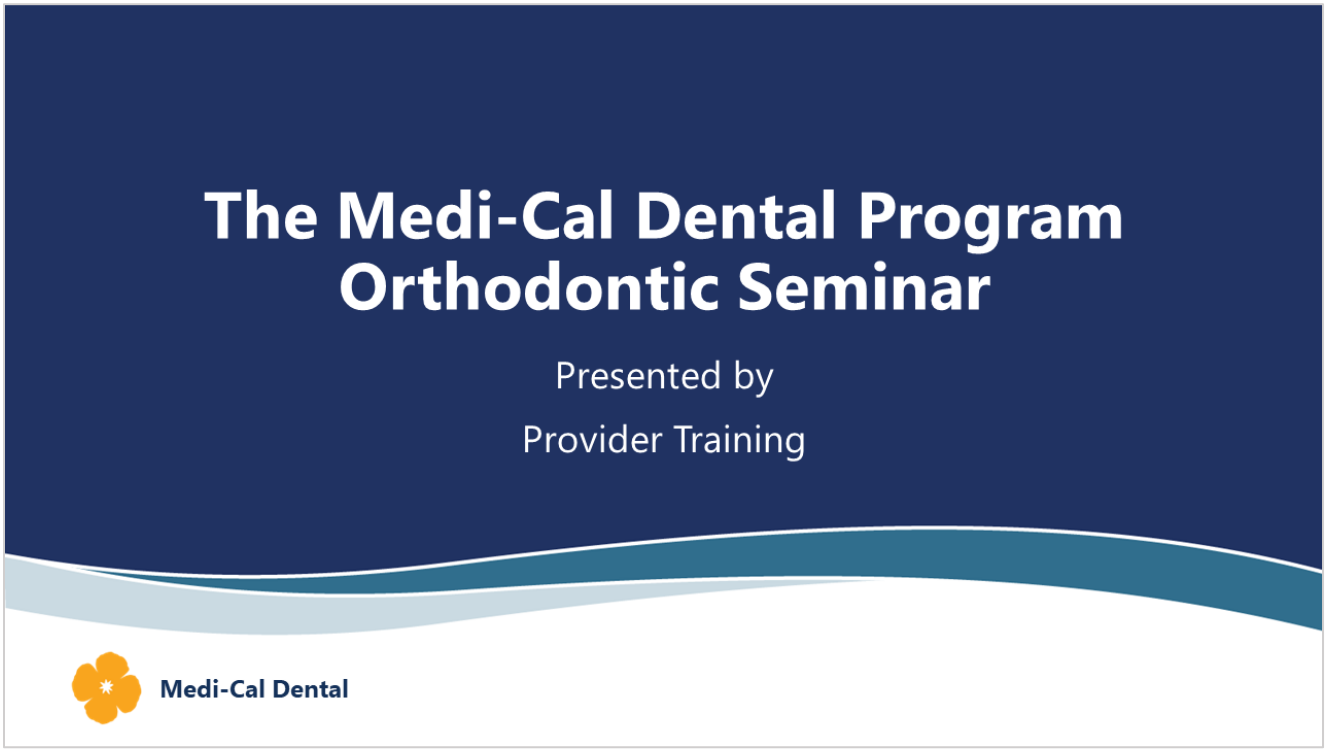
Medi-Cal Dental

Table of Contents

Introduction

This packet contains the information discussed in today's seminar regarding the orthodontic program and basic billing procedures and the use of forms. Please refer to the 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 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:

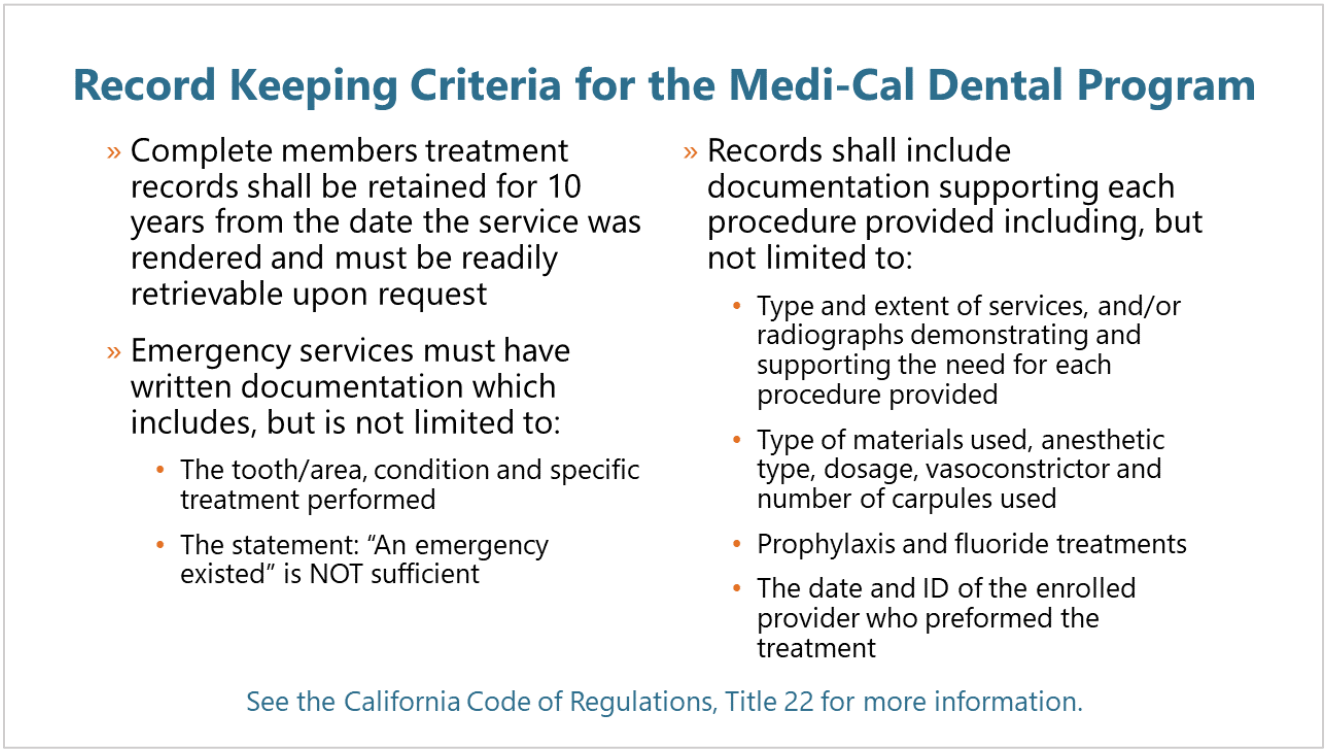
- Customer service
- Treatment Authorization Request (TAR) and Claim processing
- Distribution of checks
- Distribution of the Explanation of Benefits (EOB)
- Enforcement of the rules and guidelines set by DHCS

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.

Orthodontic Program

Orthodontic benefits for eligible individuals under the age of 21 are available under the California Medi-Cal Dental program 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.

Orthodontic Program Benefits

- In February 1991, the Medi-Cal Dental program expanded it's benefits to include orthodontic care
- Orthodontic benefits are to age 21, with no extended benefits
- Are only provided for the following medically necessary conditions:
  - Handicapping Malocclusion
  - Cleft Palate/Lip
  - Craniofacial Anomalies

Enrollment and Certification

To participate in the Orthodontic program:

1. Providers must enroll as a Qualified Orthodontist

   and

2. Be in an 'active" Medi-Cal Dental enrollment status

Certification for Medi-Cal Dental Orthodontist

» Section 51223, Title 22, the California Code of Regulations defines a qualified orthodontist as meeting the following requirements:

- The Orthodontist must confine his/her practice to the specialty of orthodontics, and
- Has successfully completed a course of advanced study in orthodontics for two years or more in programs recognized by the council on dental education of the American Dental Association, or
- Has had advanced training in Orthodontics prior to July 1, 1969, and is a member of, or eligible for membership in the advanced American Association of Orthodontics

National Provider Identifier (NPI) Numbers

» Obtain NPI numbers from National Plan and Provider Enumeration System (NPPES website) https://nppes.cms.hhs.gov/#/

- Type 1: Health Care Providers who are individuals, including dentists and hygienists, and sole proprietorships, regardless of multiple service office locations
- Type 2: Health Care Providers who are organizations, including dental practices, and/or individual dental practices who are incorporated

» Dental offices many need both Type 1 and Type 2 NPI numbers:

- An individual dentist at one practice location where a Type 1 is needed for the dentist and a Type 2 for the practice if claims are submitted using the practice's name and Tax Identification Numbers (TINs)
- Multiple dentists at one practice location where a Type 1 is needed for each dentist and a Type 2 for the practice if claims are submitted using the practice's name & TIN

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)

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 Medi-Cal Dental, 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 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).

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 the Medi-Cal Dental Program 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

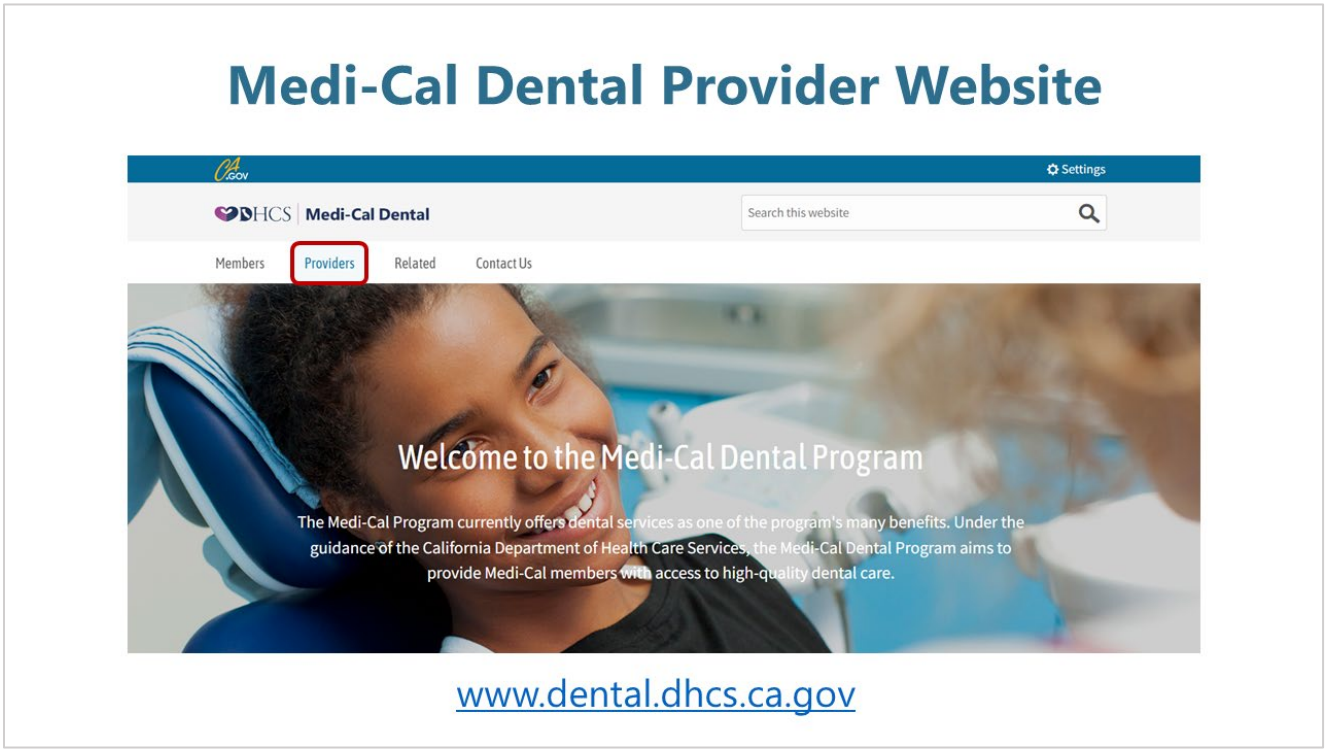
Care Coordination services are offered by the Customer Service Center (CSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our CSC agents, who assist members with: Locating a General or Specialist Dentist, Accessing Appointments, 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

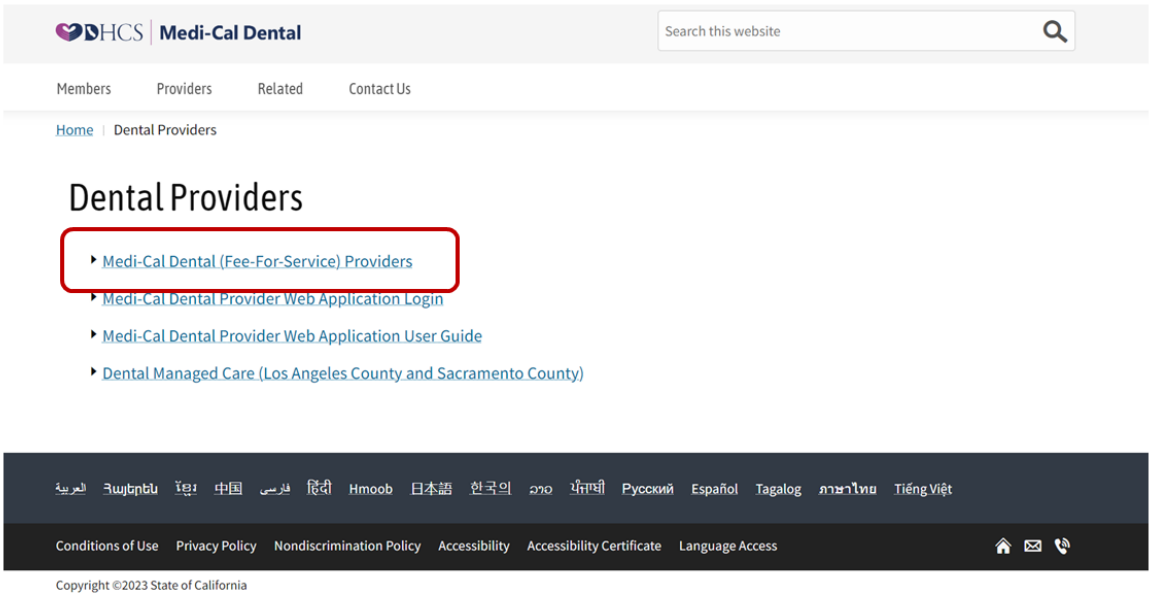
The Medi-Cal Dental Provider Handbook and Medi-Cal Dental Bulletins are available on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

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.

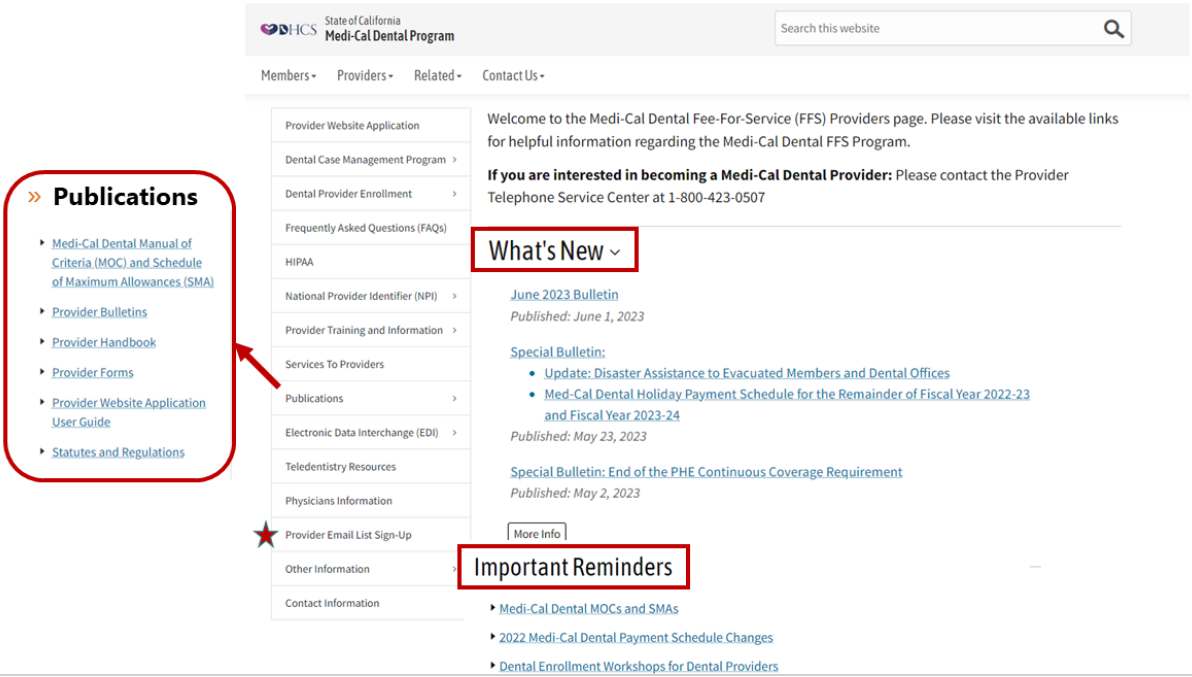
The Medi-Cal Dental Bulletins are published periodically to keep providers informed of the latest developments in the program. New bulletins will appear in the “What’s New Section” of the Medi-Cal Dental website and are incorporated into the “Provider Bulletins” section of the website. This section should 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



Medi-Cal Dental Website



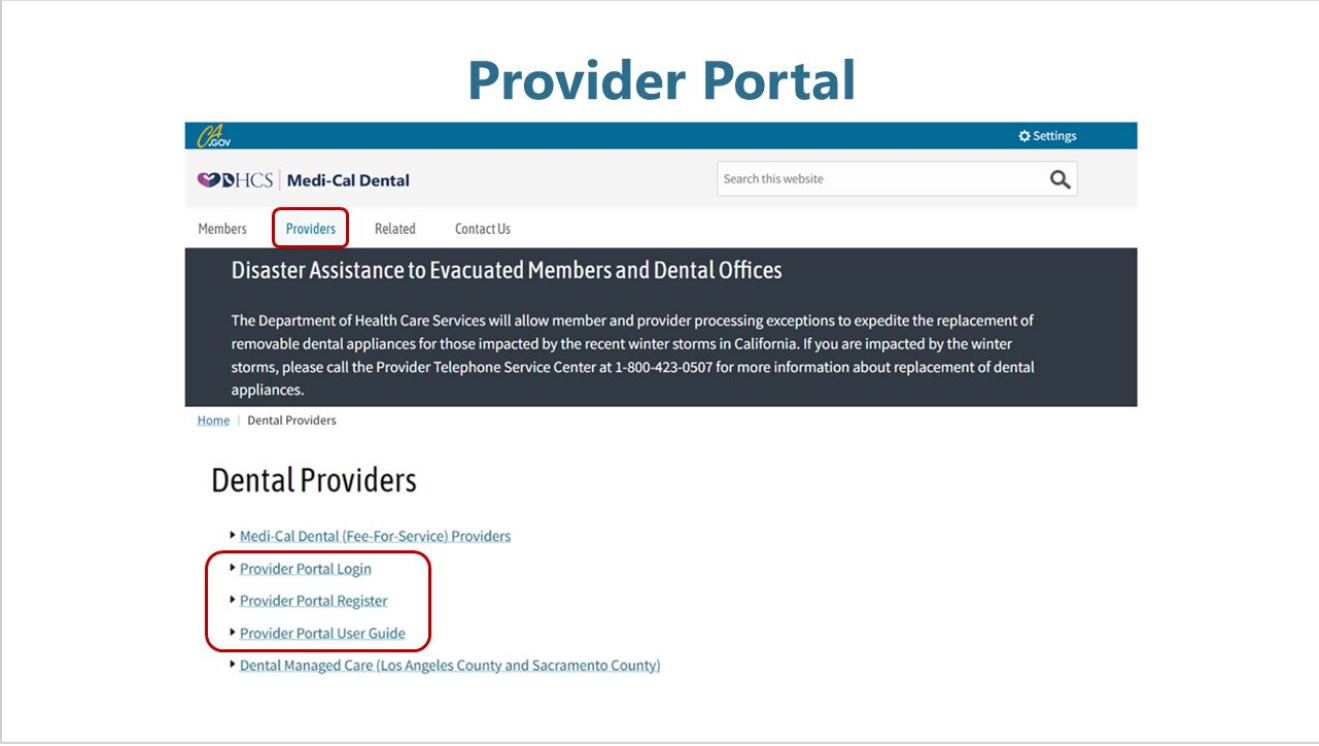
Medi-Cal Dental Provider Portal

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:

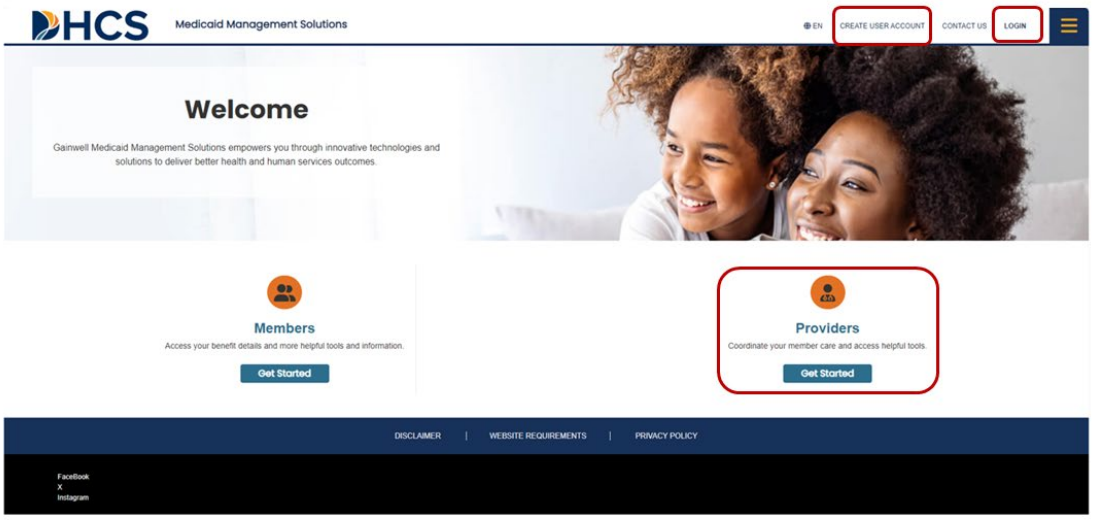
- Tooth information
- Procedure(s)
- Dates of service
- Denied/allowed status

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

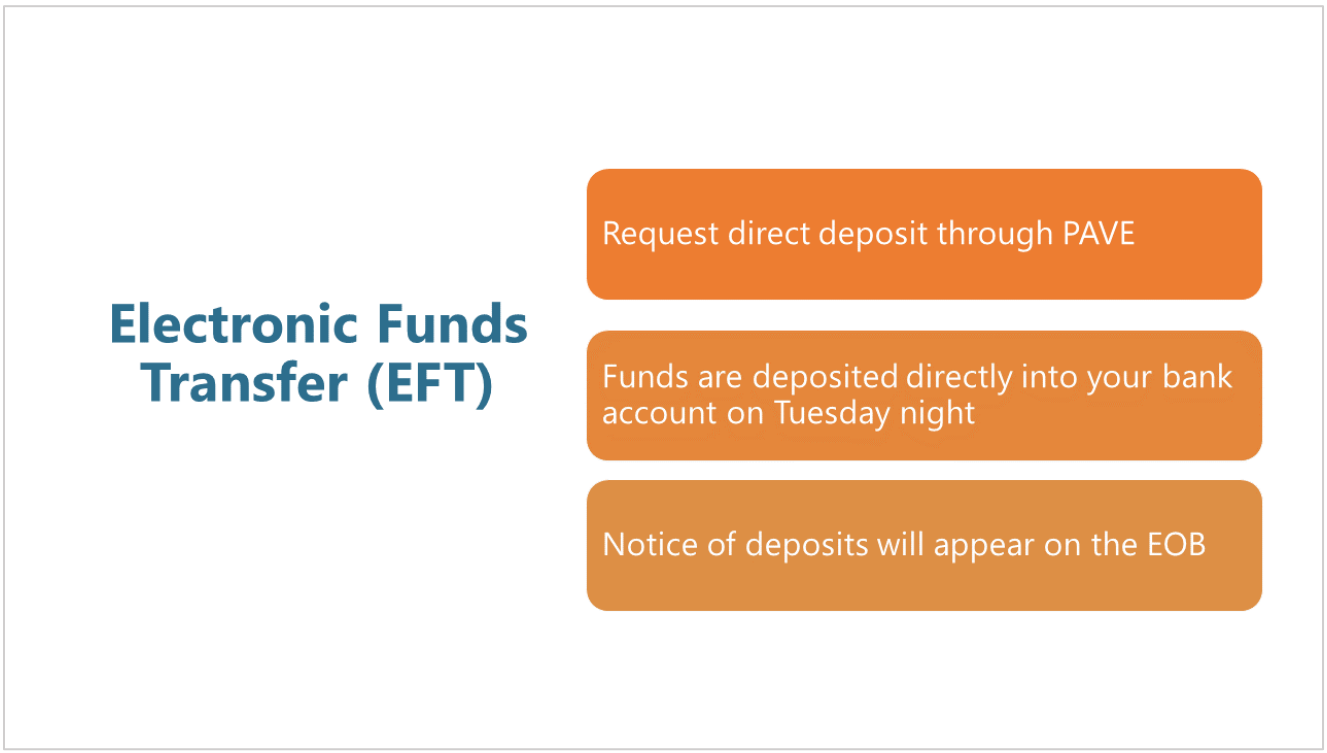
Enrollment: Welcome Packet

- 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 Medi-Cal Dental. 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 Medi-Cal Dental. 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.

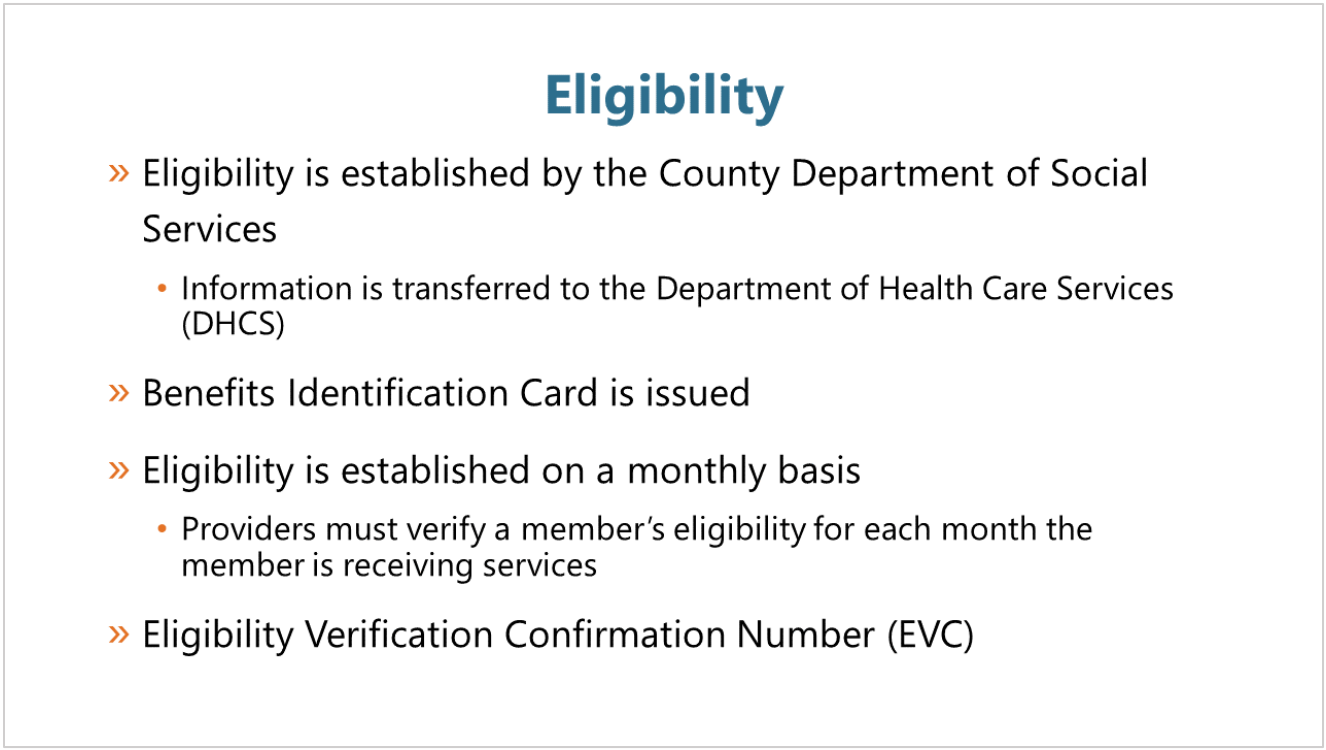
- CSC Agents are available Monday-Friday from 8:00 am – 5:00 pm
- Excluding State holidays

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



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:

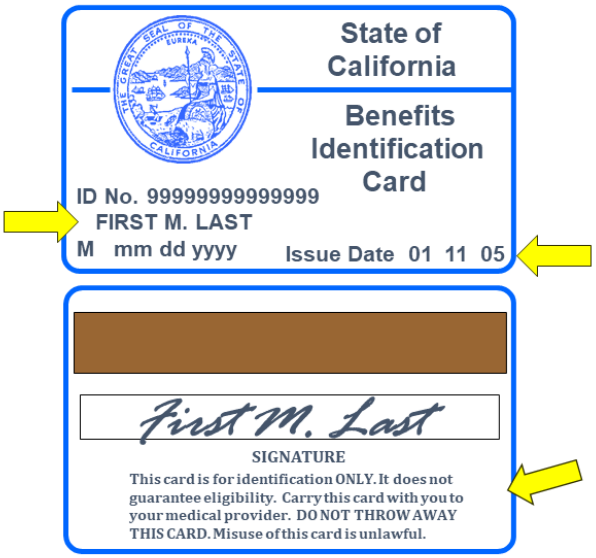
- A California driver’s license
- An identification card issued by the Department of Motor Vehicles
- Any other document which appears to validate and establish identity

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

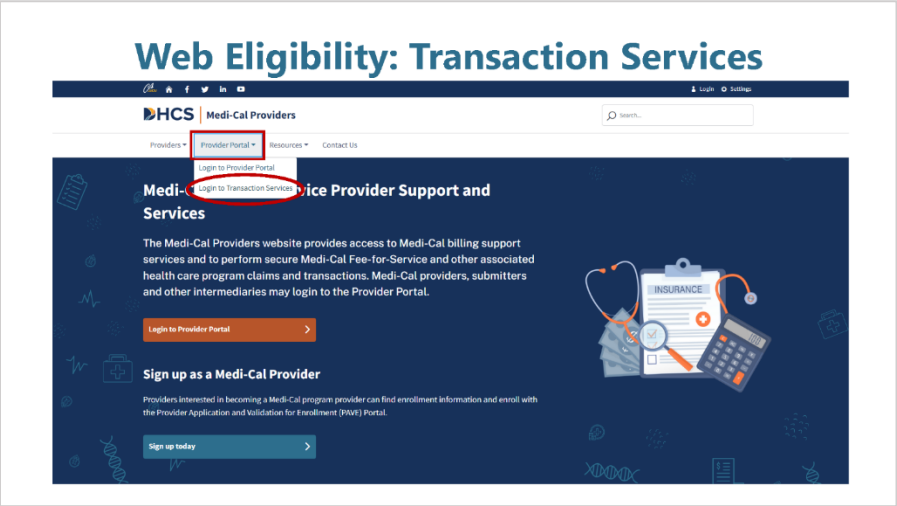
The Medi-Cal website www.medi-cal.ca.gov allows providers to verify eligibility and update Share of Cost liability. This secure site is accessed by using the billing provider number and PIN.

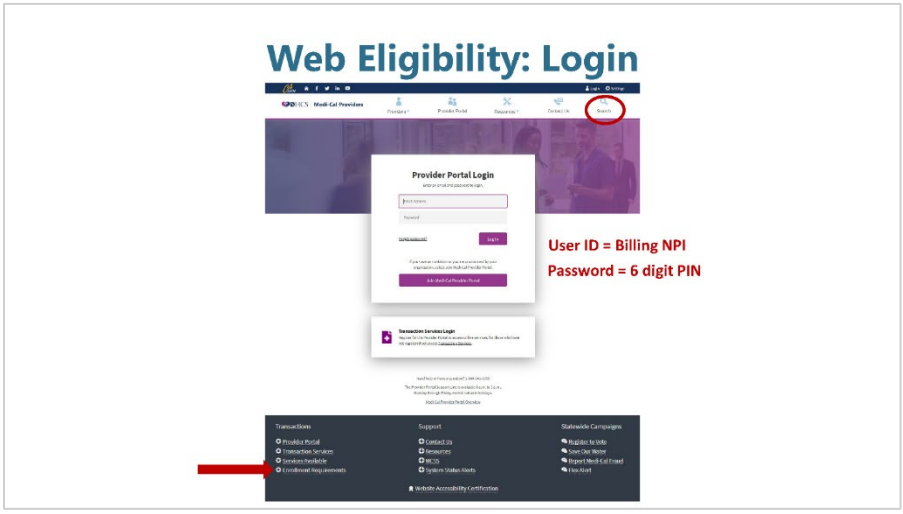
Custom Applications

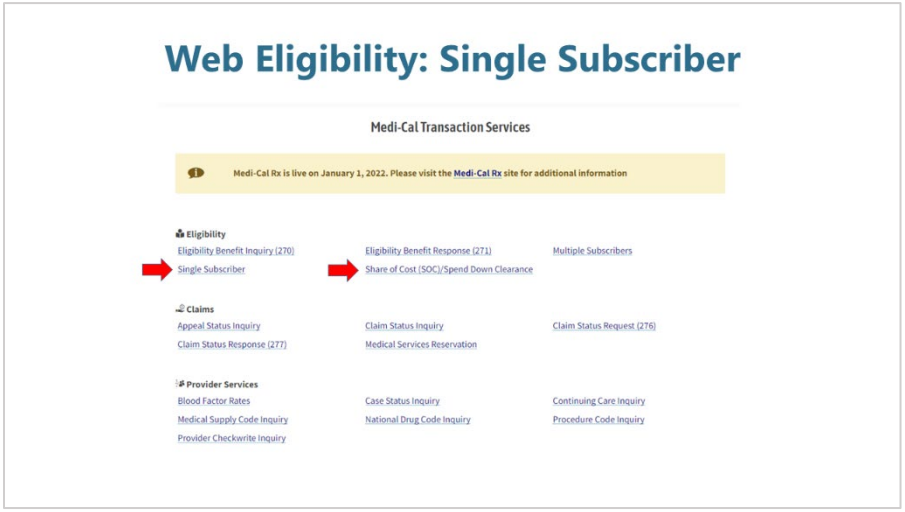
Providers with large claim volume and extensive computer systems may require custom applications to allow their system to interface with the POS network. The technical specifications to develop the program are available at no charge. The same eligibility and SOC information will be available to those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

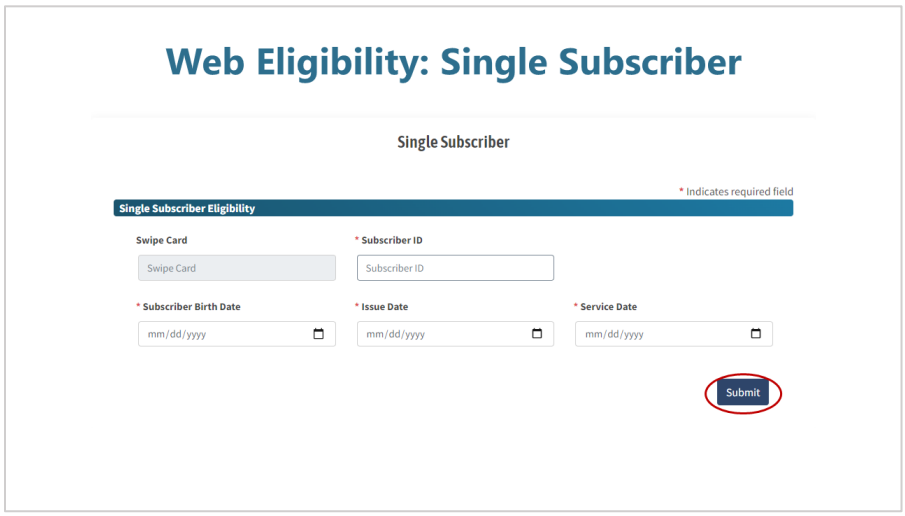
Eligibility Verification Confirmation (EVC)

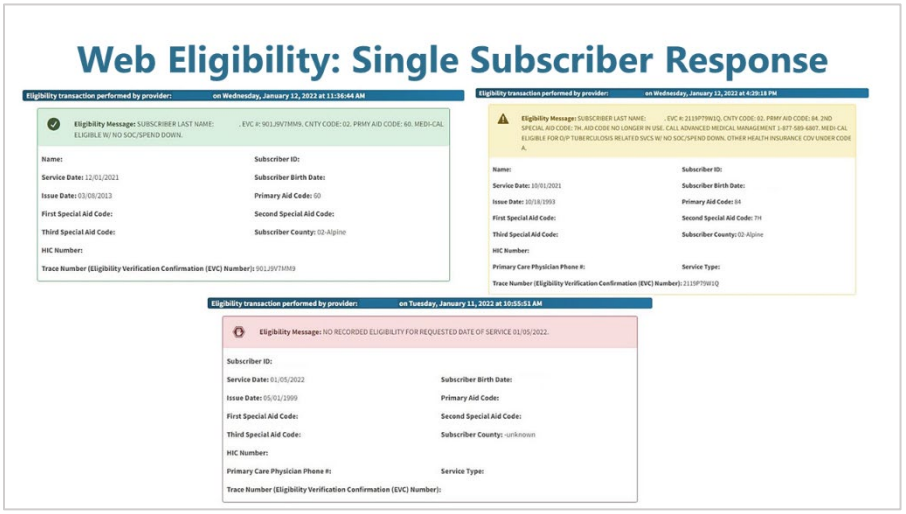
If the member's eligibility has been established for the month requested, an EVC number is received. This number should be recorded in the patient record. Please enter the EVC number in the field available on the Treatment Authorization Request (TAR)/Claim form, or in Box 23 on the Notice Of Authorization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

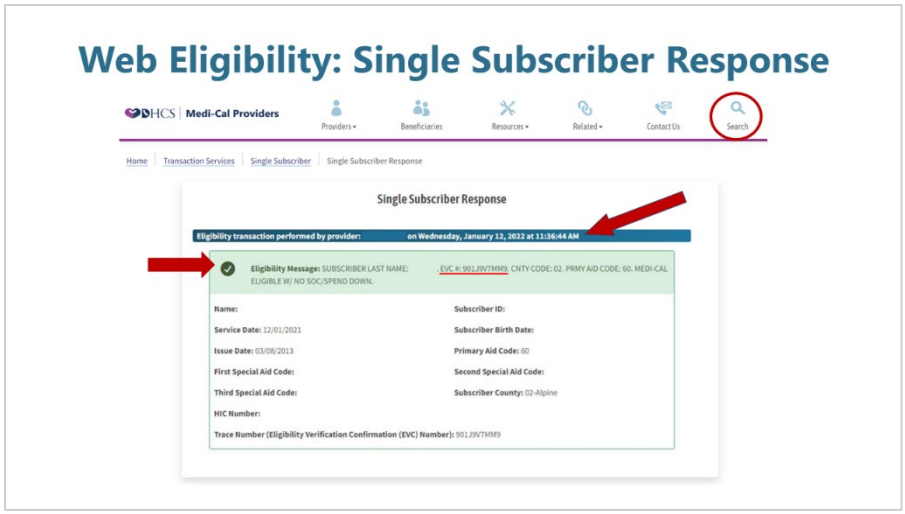

Web Eligibility: Transaction Services
DHCS | Medi-Cal Providers
Providers
Provider Portal
Resources
Contact Us
Login to Provider Portal
Login to Transaction Services
Medi-Cal Provider Support and Services
The Medi-Cal Providers website provides access to Medi-Cal billing support services and to perform secure Medi-Cal Fee-for-Service and other associated health care program claims and transactions. Medi-Cal providers, submitters and other intermediaries may login to the Provider Portal.
Login to Provider Portal
Sign up as a Medi-Cal Provider
Providers interested in becoming a Medi-Cal program provider can find enrollment information and enroll with the Provider Application and Validation for Enrollment (PAVE) Portal.
Sign up today
INSURANCE


Web Eligibility: Login
Provider Portal Login
User ID = Billing NPI
Password = 6 digit PIN
Transactions
Support
Statewide Campaigns


Web Eligibility: Single Subscriber
Medi-Cal Transaction Services
Medi-Cal Rx is live on January 1, 2022. Please visit the Medi-Cal Rx site for additional information
Eligibility
Eligibility Benefit Inquiry (270)
Single Subscriber
Eligibility Benefit Response (271)
Share of Cost (SOC)/Spend Down Clearance
Multiple Subscribers
Claims
Appeal Status Inquiry
Claim Status Response (277)
Claim Status Inquiry
Medical Services Reservation
Claim Status Request (276)
Provider Services
Blood Factor Rates
Medical Supply Code Inquiry
Provider Checkwrite Inquiry
Case Status Inquiry
National Drug Code Inquiry
Continuing Care Inquiry
Procedure Code Inquiry


Web Eligibility: Single Subscriber
Single Subscriber
* Indicates required field
Single Subscriber Eligibility
Swipe Card
* Subscriber ID
Swipe Card
Subscriber ID
* Subscriber Birth Date
* Issue Date
* Service Date
mm/dd/yyyy
mm/dd/yyyy
mm/dd/yyyy
Submit


Web Eligibility: Single Subscriber Response
Eligibility transaction performed by provider: on Wednesday, January 12, 2022 at 11:36:44 AM
Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: 901J9V7MM9. CNTY CODE: 02. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.
Name:
Subscriber ID:
Service Date: 12/01/2021
Subscriber Birth Date:
Issue Date: 03/08/2013
Primary Aid Code: 60
First Special Aid Code:
Second Special Aid Code:
Third Special Aid Code:
Subscriber County: 02-Alpine
HIC Number:
Trace Number (Eligibility Verification Confirmation (EVC) Number): 901J9V7MM9
Eligibility transaction performed by provider: on Wednesday, January 12, 2022 at 4:39:18 PM
Eligibility transaction performed by provider: on Tuesday, January 11, 2022 at 10:55:51 AM
Eligibility Message: NO RECORDED ELIGIBILITY FOR REQUESTED DATE OF SERVICE 01/05/2022.
Service Date: 01/05/2022
Issue Date: 05/01/1999
Subscriber County: -unknown
Primary Care Physician Phone #:
Service Type:


Web Eligibility: Single Subscriber Response
DHCS | Medi-Cal Providers
Providers
Beneficiaries
Resources
Related
Contact Us
Search
Home
Transaction Services
Single Subscriber
Single Subscriber Response
Single Subscriber Response
Eligibility transaction performed by provider: on Wednesday, January 12, 2022 at 11:36:44 AM
Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: 901J9V7MM9. CNTY CODE: 02. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.
Name:
Subscriber ID:
Service Date: 12/01/2021
Subscriber Birth Date:
Issue Date: 03/08/2013
Primary Aid Code: 60
First Special Aid Code:
Second Special Aid Code:
Third Special Aid Code:
Subscriber County: 02-Alpine
HIC Number:
Trace Number (Eligibility Verification Confirmation (EVC) Number): 901J9V7MM9

Aid Codes

Know the aid code(s): Not everyone receiving Medi-Cal has full-scope benefits. A member may be given aid codes that reflect limited or restricted coverage. Some members are limited to medical benefits only, such as ambulatory pre-natal care services. An example of restricted benefits would be emergency or pregnancy-related services only. These members would not be eligible for orthodontic care under the Medi-Cal Dental program.

Other Insurance Coverage

The eligibility message may also indicate other coverage information if it applies. A member may have orthodontic benefits through another dental plan. Remember that Medi-Cal will always be the secondary carrier to all other coverage.

Each request for payment must include a copy of the Explanation of Benefits (EOB), fee schedule, or letter of denial from the other carrier. Even with other coverage, orthodontic treatment must still be prior authorized by the Medi-Cal Dental program.

If a member is enrolled in a Managed Care Plan (MCP), Prepaid Health Plan (PHP), or Health Maintenance Organization (HMO) that includes dental benefits, orthodontic treatment must be rendered by a provider enrolled in that plan. There is no coordination of benefits with the Medi-Cal Dental Fee-For-Service (FFS) program.

Share of Cost

Share-of-Cost (SOC) information will be given in the eligibility message if it applies to the member. A SOC message will specify how much the member must agree to pay before becoming eligible for Medi-Cal benefits for the month. SOC is a procedure the Department of Health Care Services developed to ensure that an individual or family meets a predetermined financial obligation before receiving Medi-Cal benefits. This procedure is used to compute the dollar amount to be applied to any health care costs. Health care costs could be dental, medical, hospital or pharmaceutical charges. Always use usual, customary and reasonable (UCR) fees. If the SOC has been met when an update has been entered in the eligibility system, it will reflect this information or show the amount remaining. When updating SOC, do so by procedure code, not by the total amount for the visit.

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

Instructions For Share of Cost (SOC) Clearance Using the Automated Eligibility Verification System (AEVS)

To perform a SOC clearance using the AEVS, follow these steps:

- Call AEVS at 800-456-AEVS (2387)
- Enter the 6 digit PIN number (not the same as the NPI)
- Press ‘2’ for the share of cost menu
- Press ‘1’ to perform an update (clearance)
- Enter the member ID number, then the pound sign (#)
- Enter the 2 digit month and 4 digit year of the member’s birth date
- Enter the date of service, using 2 digits for the month, 2 digits for the day, and 4 digits for the year. (For example: Enter March 5, 2017, as 03 05 2017)
- Enter the appropriate procedure code using the CDT 22 code format, followed by the (#)
- Enter the total amount billed in the format of dollars followed by the star sign, and cents followed by the pound sign. (For example: $20.50 would be entered as 20*50#)

Verify that the amount is entered correctly by pressing ‘1’ for ‘yes’ or ‘2’ for ‘no’. If '2' is pressed, re-enter the amount. If '1' is pressed, enter the case number (if applicable) followed by the (#) sign.

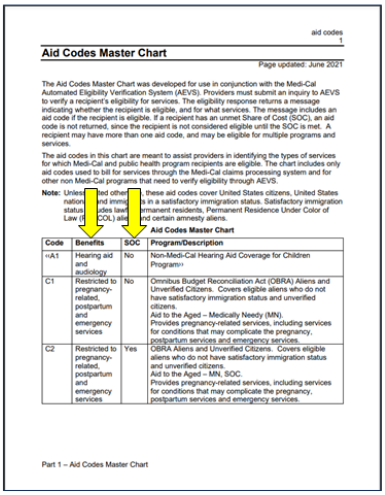
If the SOC is not fully satisfied, the amount deducted and the amount remaining will be indicated. If the SOC is satisfied, the following information will be received:

- The first 6 letters of the last name
- The first initial of the first name
- The Eligibility Verification Confirmation (EVC) number
- The county code
- The aid code
- The amount deducted
- A message indicating the SOC is certified (cleared)
- A message indicating what type of eligibility the member has and if there are any restrictions or limitations to benefits

Eligibility can be delayed when other health care providers do not report payments made by the member. Instruct the member to take their receipt of payment to their caseworker so an update may be done. An alternative is to contact the other health care provider and ask that the SOC be updated immediately on behalf of the member.

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.

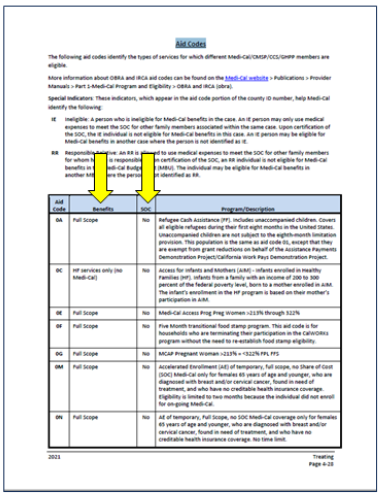
The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and public health program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing system and for other non Medi-Cal programs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

Note: Unless [illegible] these aid codes cover United States citizens, United States nationals, and immigrants in a satisfactory immigration status. Satisfactory immigration status includes lawful permanent residents, Permanent Residence Under Color of Law (PRUCOL) aliens, and 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/CCS/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 required to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not 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 01, 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% < 53(2% FPL FF)
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 4-28

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

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

Orthodontic Billing Forms and Procedures

Orthodontic services are limited to only those who meet the general policies and requirements for medically necessary handicapping malocclusion, cleft palate, or cranio- facial anomalies cases set forth in Title 22 of the California Code of Regulations. Eligibility for these services end when the member reaches the age of 21, with no extended services allowed.

In administering the California Medi-Cal Dental program, Delta Dental's 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 Delta Dental to process claims and TARs as quickly and efficiently as possible. The forms used for billing as well as other related documents have been developed to simplify billing procedures. The forms, in both manual and computer-compatible formats, are available from the Medi-Cal Dental forms supplier at no charge to providers.

The Handbook contains detailed, step-by-step instructions for completing each of the Medi- Cal Dental forms. Section 6: Forms, contains a handy checklist to help complete treatment forms accurately. Section 9: Special Programs, contains detailed information specific to the orthodontic program, including procedures and orthodontic claims processing.

All incoming documents are received and sorted by Gainwell Technologies. Claims and TARs are separated from other incoming documents and general correspondence. Orthodontic treatment forms are assigned a unique 11-digit Document Control Number or DCN. The DCN is important because it identifies specific treatment forms so Medi-Cal Dental can tell exactly where it is in the processing system, what has been done to that point, and if appropriate, what needs to be done to reach the final point of authorization or payment. By knowing this information, Medi-Cal Dental can answer inquiries concerning the status of any treatment form received.

The dental office must accurately complete treatment forms to ensure proper and expeditious handling by The Medi-Cal Dental program. A form which is incomplete or inaccurate causes delays in processing and/or requests for additional information. Please ensure the required information is typed or printed clearly on the form.

CDT 23 Procedures codes

- D0140 = Limited oral evaluation
- D0470 = Diagnostic casts
- D8080 = Comprehensive orthodontic treatment of the adolescent dentition (for all case type - fees will vary)
- D8660 = Pre-Orthodontic treatment visit (for craniofacial anomalies cases only)
- D8670 = Periodic orthodontic treatment visit (for all case types – fees will vary)
- D8680 = Orthodontic retention (for all case types)

Clarification of Case Types

Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If malocclusion cases require further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review. Progress photos must be submitted when requesting additional visits.

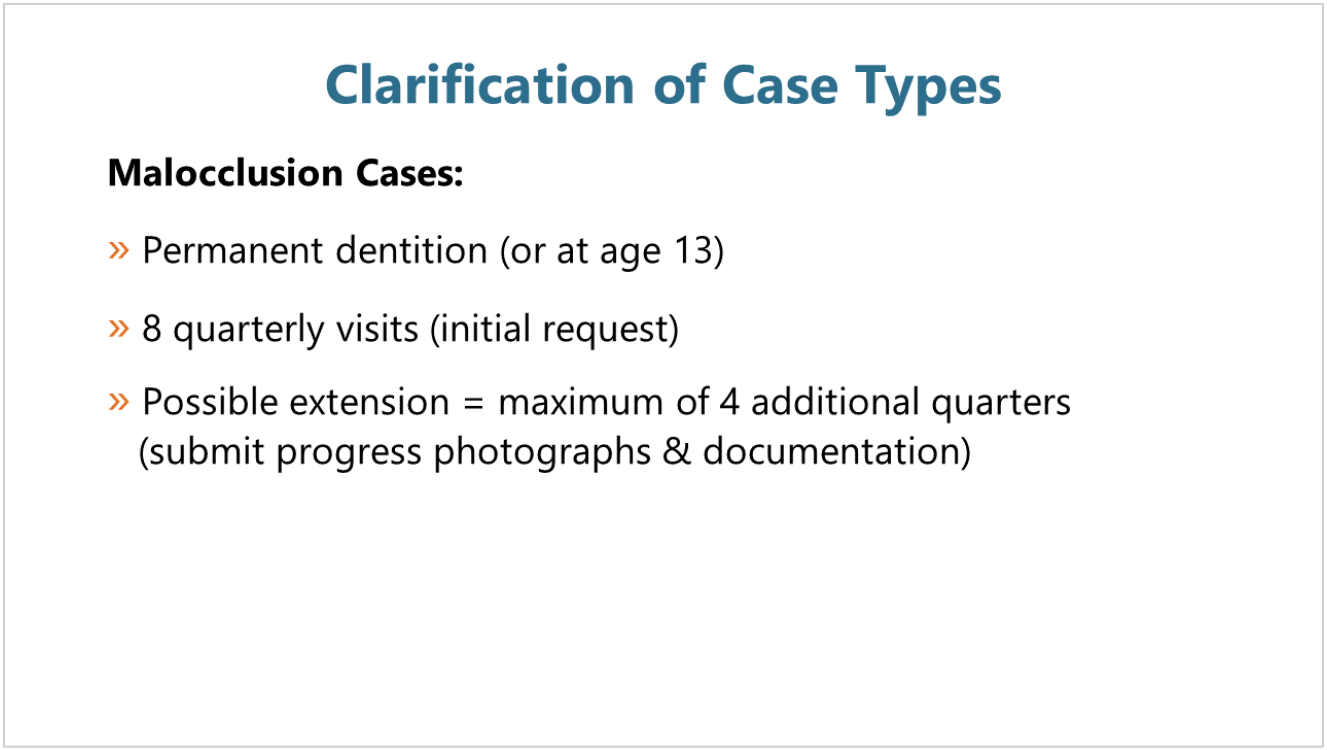
Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition, and again in the permanent dentition phase. Submission of the diagnostic casts is not required if the cleft palate cannot be demonstrated on the casts. However, photographs or documentation from a credentialed specialist must be attached. If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photos and documentation. If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photos and documentation. If the permanent dentition case requires further treatment beyond 10 quarterly visits, a maximum of 5 additional quarters may be authorized upon review of progress photos and documentation. If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Craniofacial Anomaly Cases

Craniofacial anomalies cases may also be treated from birth in the primary dentition phase, again in the mixed dentition, and again in permanent dentition. Submission of the diagnostic casts for the authorization of the treatment plan is optional. Documentation from a credentialed specialist is required for all craniofacial anomalies' cases. If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photos and documentation. If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photos and documentation. If the permanent dentition case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photos and documentation. If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Note: Craniofacial Anomalies cases may require Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6) to monitor the facial growth on a quarterly schedule prior to starting orthodontic treatment. This procedure is not required if the member's dentition or skeletal growth is stable, and the member is ready to start orthodontic treatment. Submit this procedure (x the number of visits requested) along with the TAR for the complete orthodontic treatment plan.



Clarification of Case Types

Cleft Palate Cases:

- Primary dentition = 4 quarterly visits (initial request)
  - Possible extension = maximum of 2 additional quarters (submit progress photographs and documentation)
- Mixed dentition = 5 quarterly visits (initial request)
  - Possible extension = maximum of 3 additional quarters (submit progress photographs and documentation)
- Permanent dentition = 10 quarterly visits (initial request)
  - Possible extension = maximum of 5 additional quarters (submit progress photographs and documentation)

Clarification of Case Types

Craniofacial Anomaly Cases:

- Primary dentition = 4 quarterly visits (initial request)
  - Possible extension = maximum of 2 additional quarters (submit progress photographs and documentation)
- Mixed dentition = 5 quarterly visits (initial request)
  - Possible extension = maximum of 3 additional quarters (submit progress photographs and documentation)
- Permanent dentition = 8 quarterly visits (initial request)
  - Possible extension = maximum of 4 additional quarters (submit progress photographs and documentation)

Step 1

Step 1

- The D0140 Limited Oral Evaluation exam is the 1st step to provide Orthodontic treatment
  - Exam includes completion of the Handicapping Labio-Lingual Deviation (HLD) Index CA Modification Score Sheet

Handicapping Labio-Lingual Deviation (HLD) Index CA Modification Score Sheet

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider **Patient**

Name:_____ **Name:**_____

Number:_____

Date:_____

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation)
   Indicate an 'X' if present and score no further..... _____
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist)
   Indicate an 'X' if present and score no further..... _____
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.**
   Indicate an 'X' if present and score no further..... _____
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT**
   Indicate an 'X' if present and score no further..... _____
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.)
   Indicate an 'X' if present and score no further..... _____

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Indicate an 'X' if present and score no further ..... _____

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm..... _____

7. Overbite in mm ..... _____

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm ..... _____ x 5 = _____

9. Open bite in mm..... _____ x 4 = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ (tooth numbers) _____ (total) x 3 = _____

11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ (maxilla) _____ (mandible) _____ (total) x 5 = _____

12. Labio-Lingual spread in mm..... _____

13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite)..... Score 4 _____

AUTHORIZATION OF SERVICES IS BASED ON MEDICAL NECESSITY. IF A PATIENT DOES NOT HAVE ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS OR DOES NOT SCORE 26 OR ABOVE, THE PATIENT MAY STILL BE ELIGIBLE FOR THESE SERVICES BASED ON EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) CRITERIA NECESSARY TO CORRECT OR AMELIORATE THE PATIENT'S CONDITION. FOR A FURTHER EXPLANATION OF EPSDT CRITERIA, PLEASE SEE THE ORTHODONTICS SECTION OF THE CALIFORNIA MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK.

DC016 (R 09/18)

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION
SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A **Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)

6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

EPSDT

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

EPSDT

- EPSDT services might or might not be part of the Manual of Criteria
  - A service is medically necessary if it corrects or ameliorates defects and physical and mental illnesses or conditions
- A TAR is required when a procedure is not listed in the Manual of Criteria, or a service does not meet the published criteria for a procedure
  - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition

EPSDT Sample

Example:

- Andre W. (age 13) does not qualify for orthodontic services per the handicapping malocclusion criteria (he scores below 26 points on the HLD Index Score Sheet or does not have one of the six automatic qualifying conditions)
- However, a speech pathologist has determined that his malocclusion is a prime etiologic factor in his speech pathosis – resolution cannot be achieved unless his malocclusion is corrected
- In this case, orthodontics may be authorized as an EPSDT service

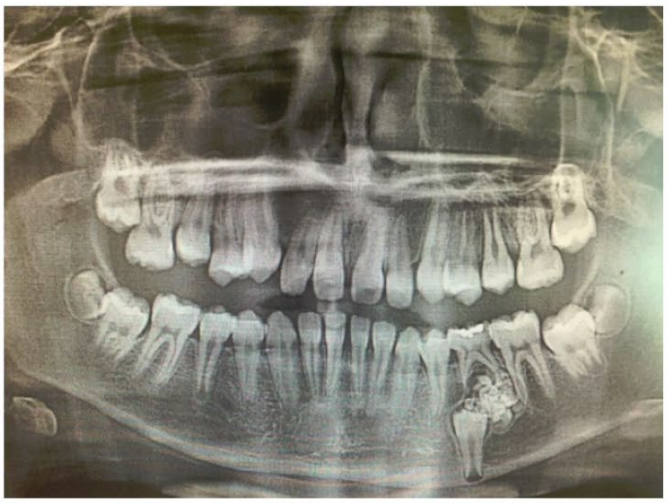
EPSDT Exception Considerations

Consideration for EPSDT exception:

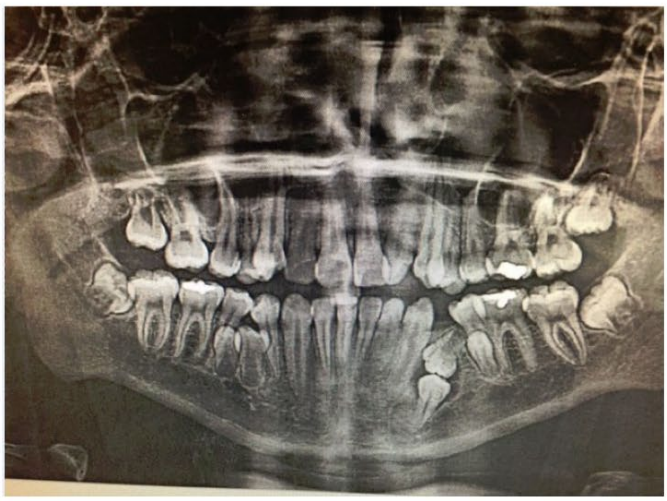
» Any case demonstrating the presence of:

- Pathology
- An impacted or unerupted tooth destroying the root of an adjacent tooth
- Attachment loss associated with anterior crossbite

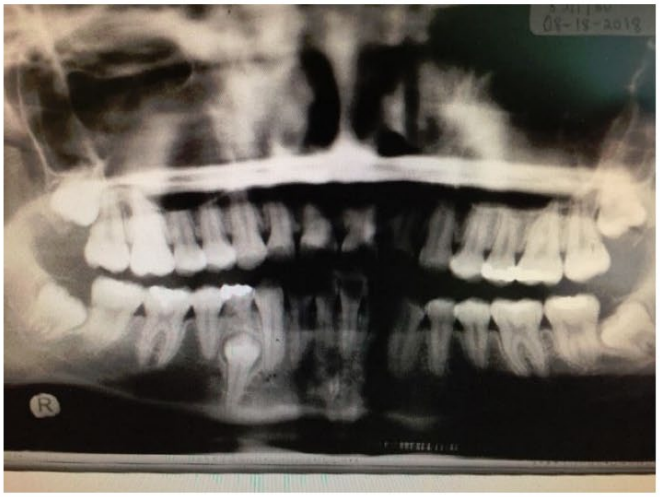
Pathology



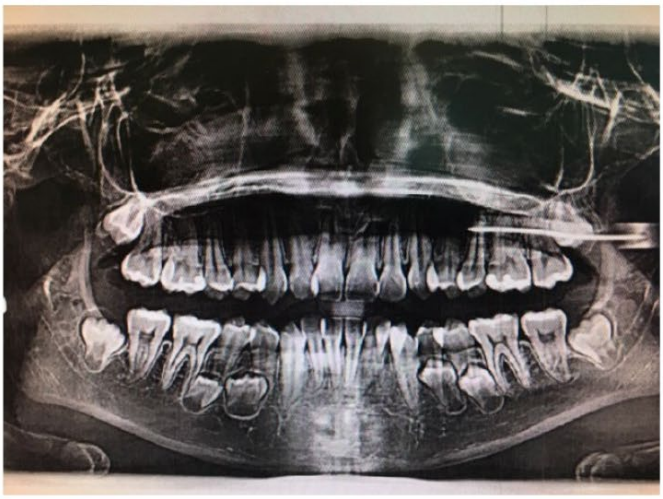
Pathology



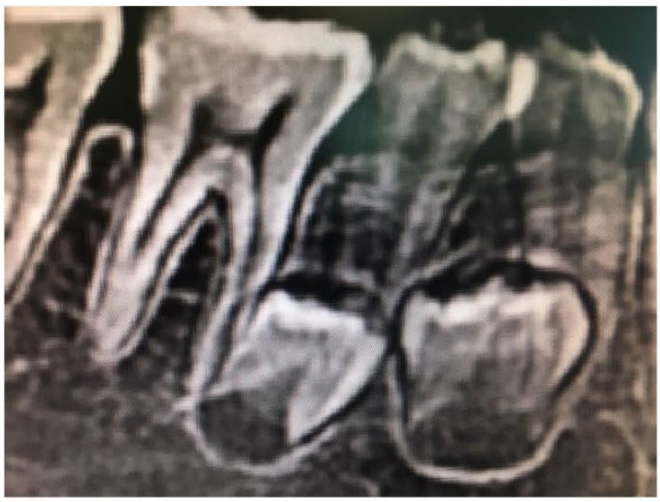
Not Pathology



Root Destruction



Root Destruction



Case Submission

- HLD Index score sheet must be completed by an orthodontist who is a graduate of an ADA accredited orthodontic residency/program

1. Cleft Palate Deformity

- Automatic qualification
- If the deformity cannot be demonstrated on the diagnostic casts, the condition must be diagnosed by properly credentialed experts and that diagnosis must be supported by an attached description
- If present, enter an "X" and score no further

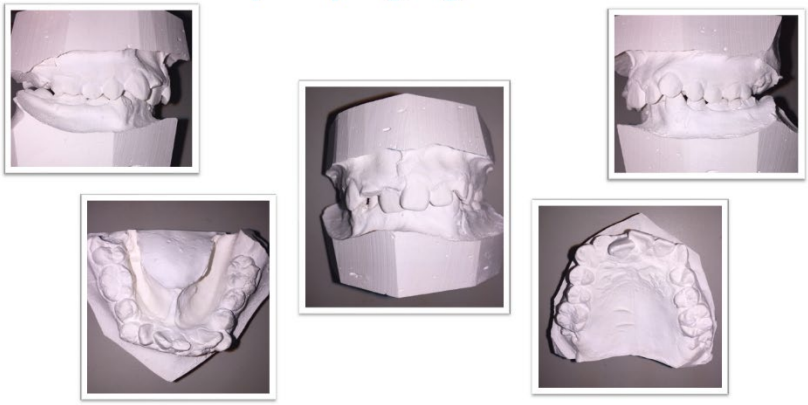
2. Cranio-facial Anomaly

- Automatic qualification
- Attach description of condition from a credentialed specialist
- Indicate an "X" and score no further

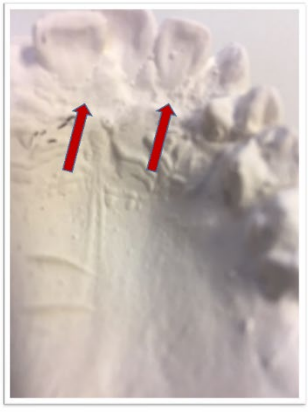
3. Deep Impinging Overbite

- Automatic qualification
- Tissue destruction of the palate must be clearly visible in the mouth
- On the diagnostic casts, the lower teeth must be clearly touching the palate and tissue indentations, or evidence of soft tissue destruction must be clearly visible
- Photographs are helpful in determining the presence of tissue damage
- Indicate an "X" and score no further

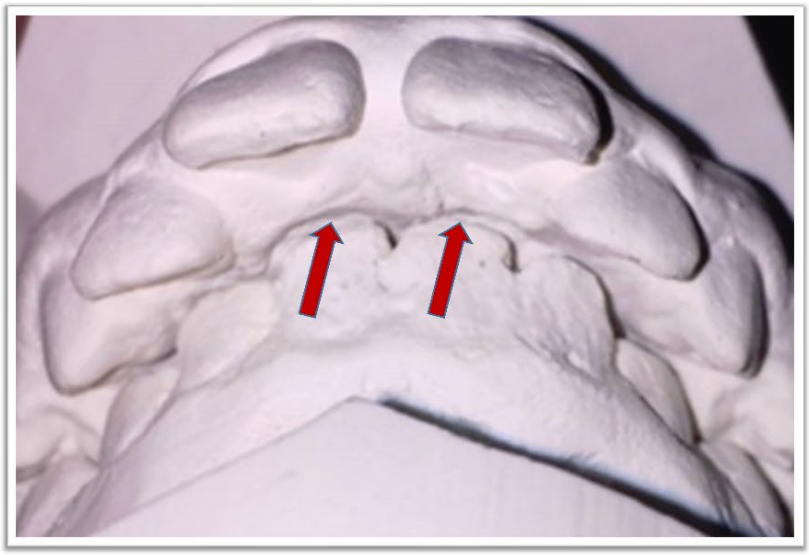
Deep Impinging Overbite



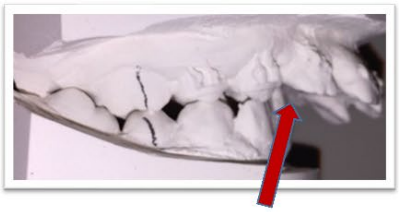
Deep Impinging Overbite

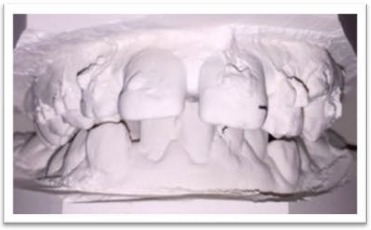


Deep Impinging Overbite



Deep Impinging Overbite

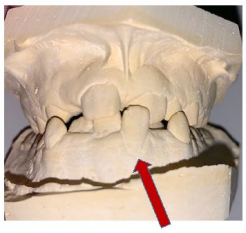




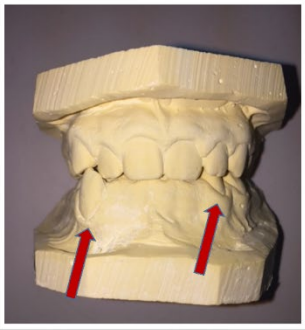
4. Crossbite of Individual Anterior Teeth

- Automatic qualification
- Destruction of soft tissue must be clearly visible in the mouth with soft tissue loss reproducible and visible on the diagnostic casts
- If present, enter an "X" and score no further

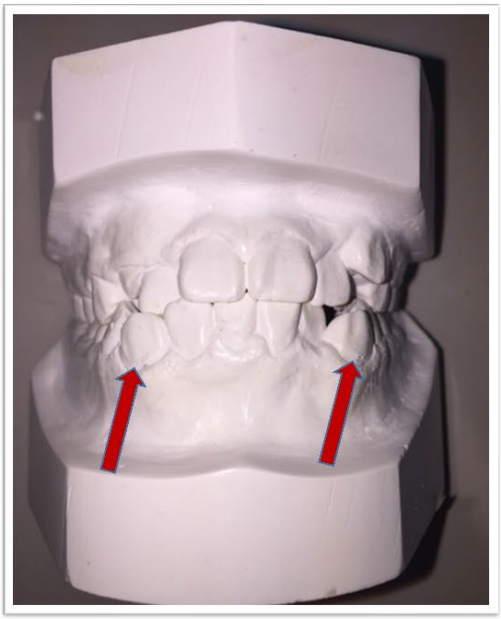
Anterior Crossbite



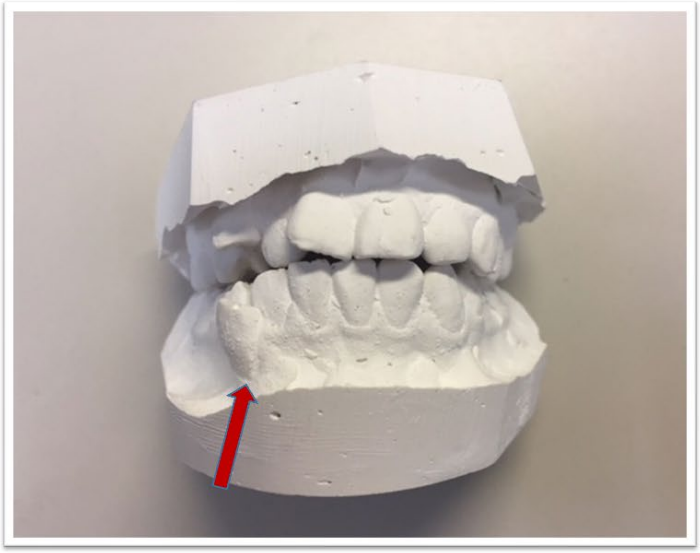
Attachment Loss



No Attachment Loss



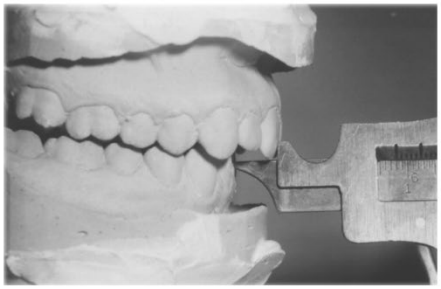
Attachment Loss NOT Caused by Anterior Crossbite



5. Severe Traumatic Deviation

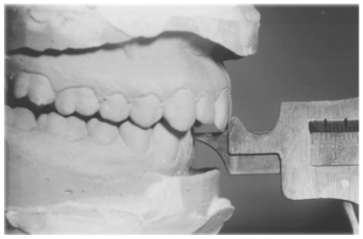
- Automatic qualification
- Examples: loss of premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology
- Attach documentation and description of condition
- If present, enter an "X" and score no further

6A. Overjet Greater Than 9mm with Incompetent Lips or Mandibular Protrusion Greater Than 3.5mm with Masticatory and Speech Difficulties

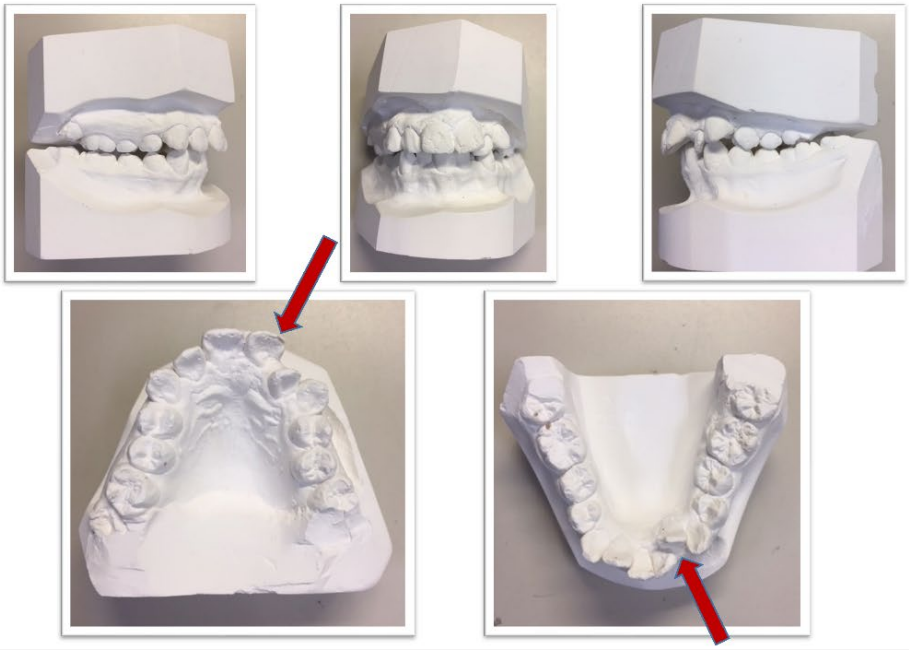


6A. Overjet Greater Than 9mm

- Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors
- This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor



Overjet

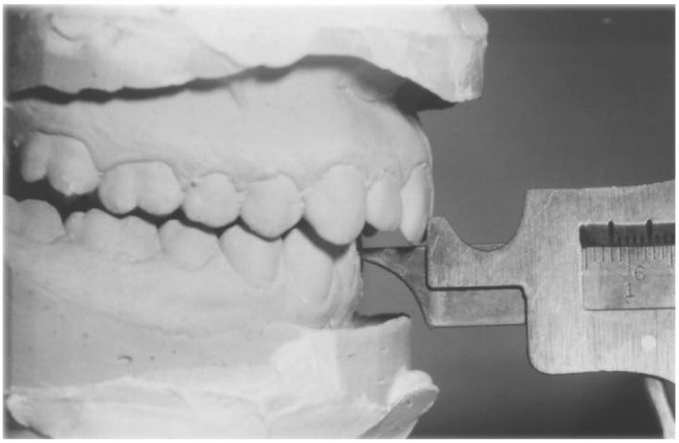


6A. Overjet Greater Than 9mm

- Automatic qualification
- If present, enter an "X" and score no further.
  - The remaining conditions must score 26 or more to qualify

6B. Overjet Equal to or Less Than 9mm

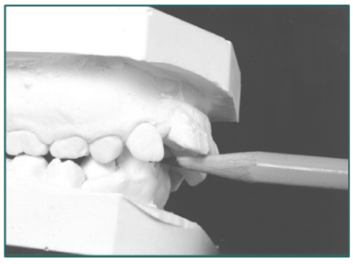
» Do not use the upper lateral incisors or cuspids

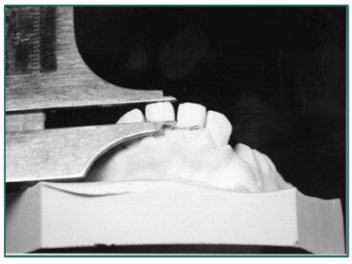


7. Overbite in mm

» Hold a pencil parallel to the occlusal plane and use the incisal edge of one of the upper central incisors to place a pencil mark indicating the extent of overlap

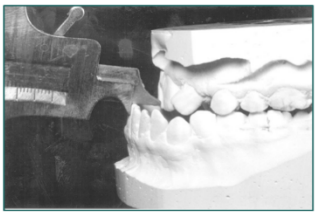
» The measurement is done on the lower incisor from the incisal edge to the pencil mark



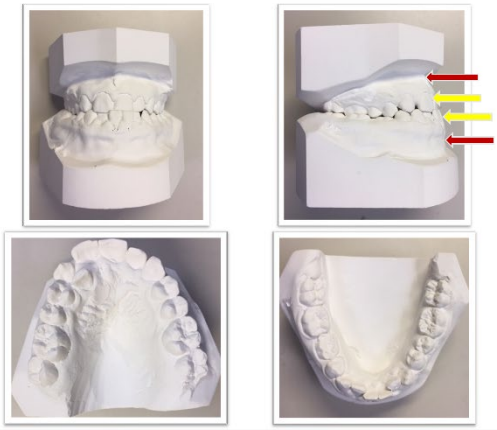


8. Mandibular Protrusion Equal to or Less Than 3.5mm

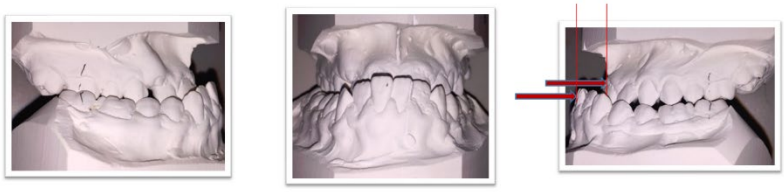
- Measured from the labial surface of a lower incisor parallel to the occlusal plane and perpendicular to the labial surface of an upper central incisor
- The measurement in millimeters is entered on the score sheet and multiplied by five



Mandibular Protrusion

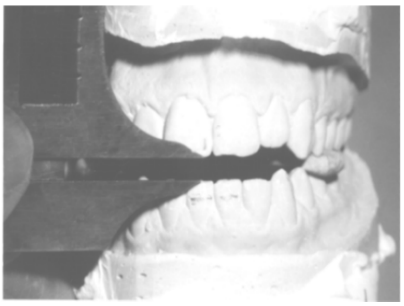


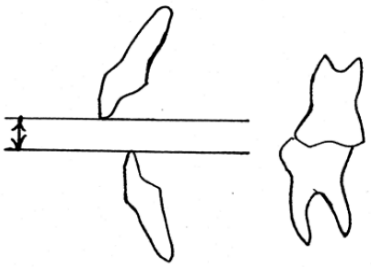
Mandibular Protrusion



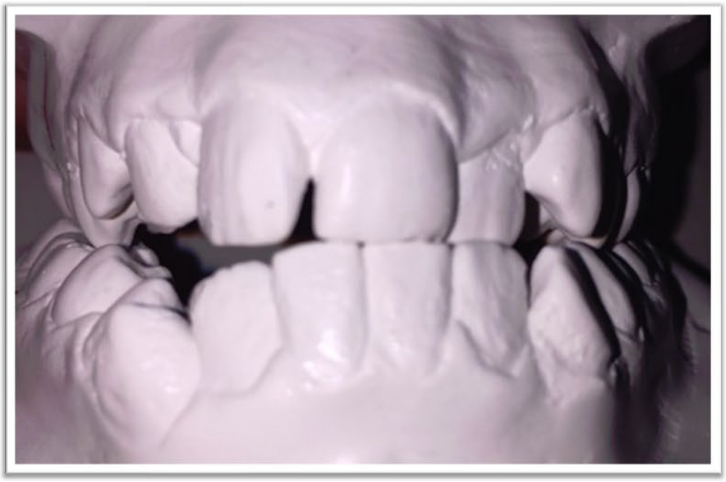
9. Open bite in mm

- Measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor
- In some situations, one has to make an approximation by measuring perpendicular to the occlusal plane





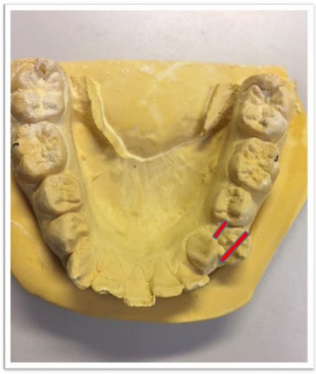
Anterior Open Bite



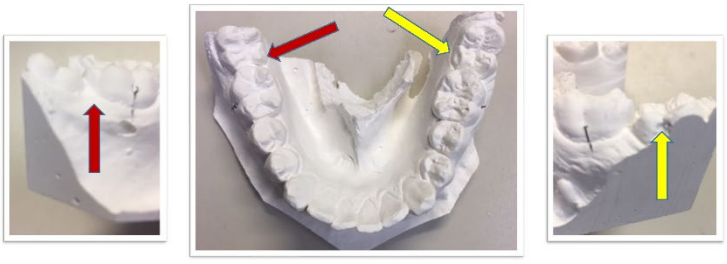
10. Ectopic Eruption

- Identify the tooth/teeth by number/s
- Count each tooth excluding third molars
- Enter the number of teeth on the score sheet and multiply by three
- If anterior crowding is present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition

Ectopic Eruption



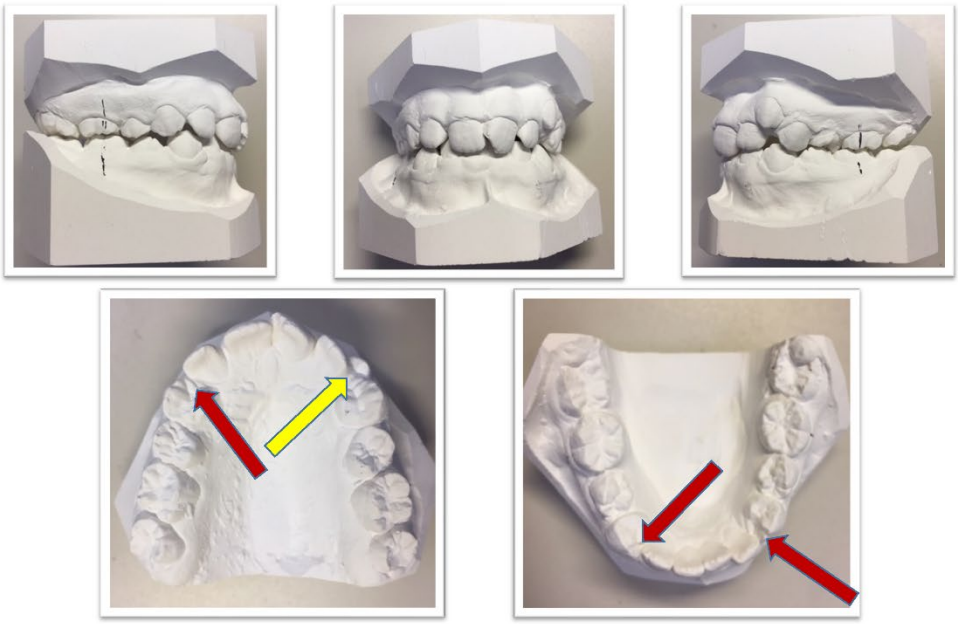
Ectopic Eruption of Second Molars



11. Anterior Crowding

- Anterior arch length insufficiency must exceed 3.5 mm
- Enter five points for a maxillary arch with anterior crowding and five points for a mandibular arch with anterior crowding
- If ectopic eruption is also present in the anterior portion of the mouth, score only the most severe condition

Anterior Crowding

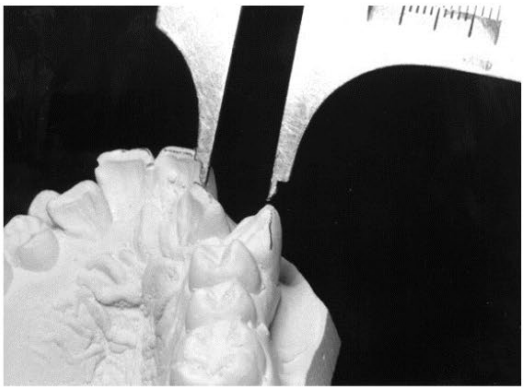


12. Labio-Lingual Spread in mm

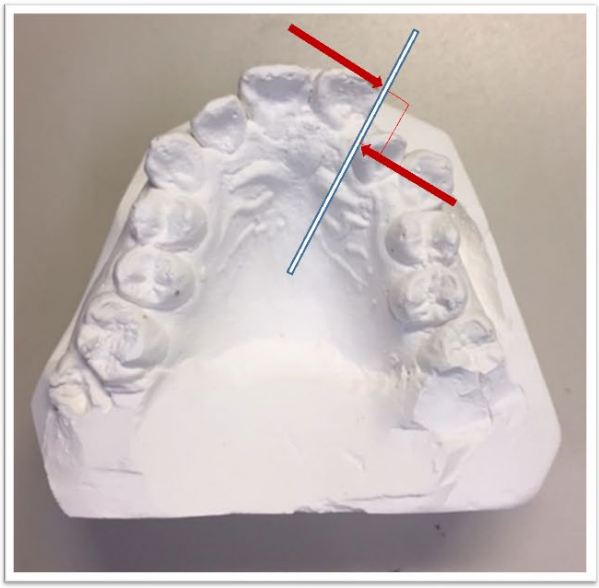
- Use a Boley gauge to determine the extent of deviation from a normal arch
- Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of the tooth to a line representing the normal arch line

12. Labio-Lingual Spread in mm

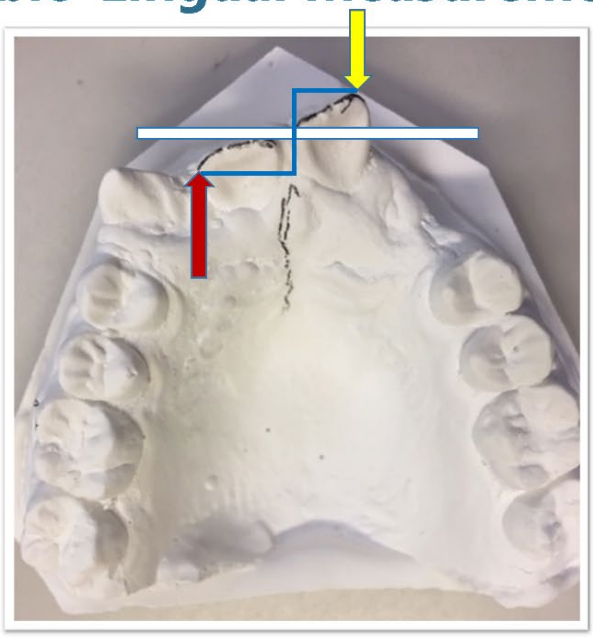
- Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured



Labio-Lingual Measurement



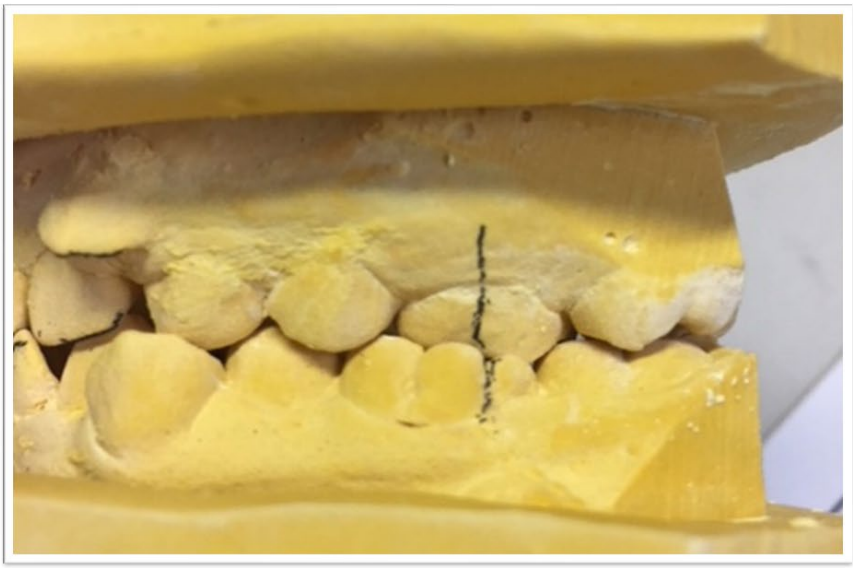
Labio-Lingual Measurement



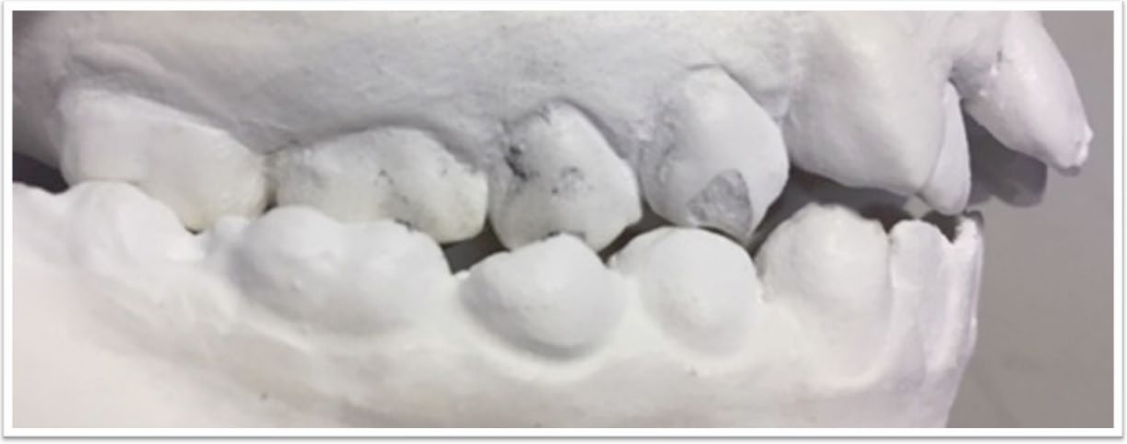
13. Posterior Unilateral Crossbite

- This condition involves two or more adjacent teeth, one of which must be a molar
- The crossbite must be one in which the two maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth
- The presence of posterior unilateral crossbite is indicated by a score of four on the score sheet
- Bilateral posterior crossbite scores as zero

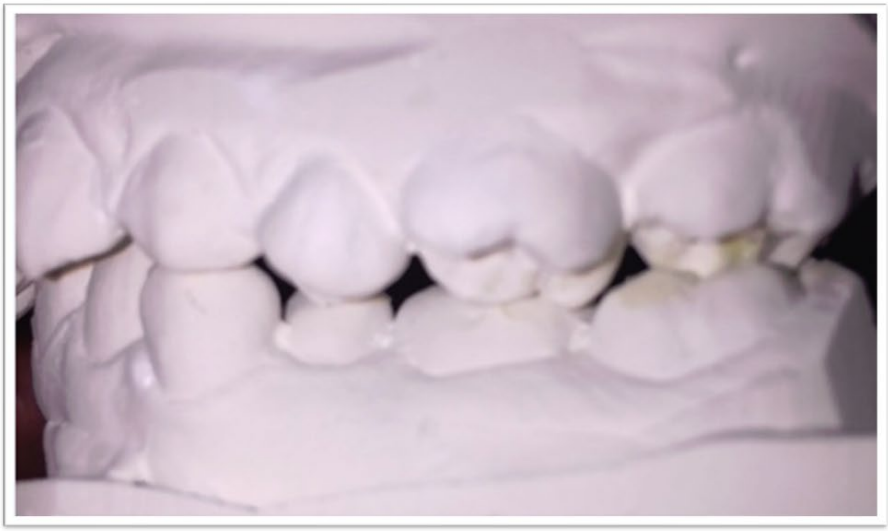
Unilateral Posterior Crossbite



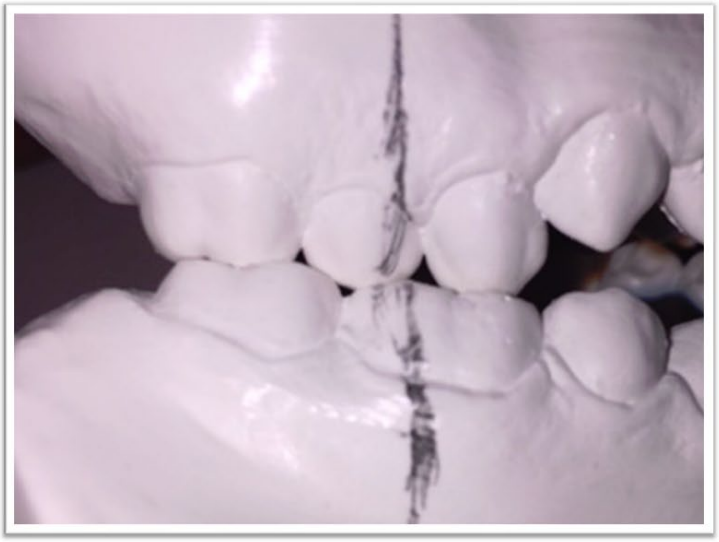
Unilateral Posterior Crossbite



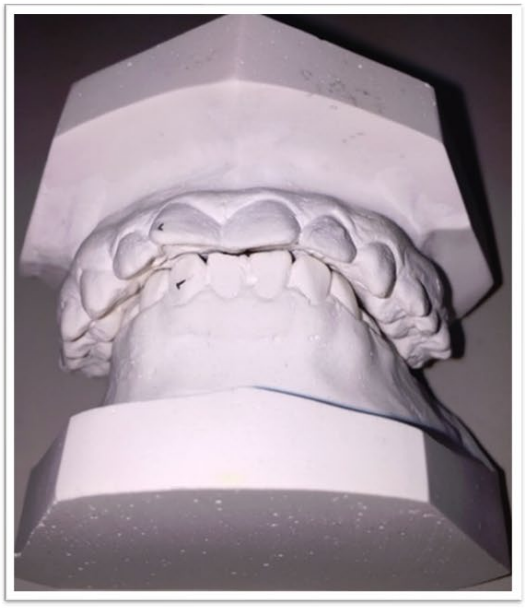
Unilateral Posterior Crossbite



Unilateral Posterior Crossbite



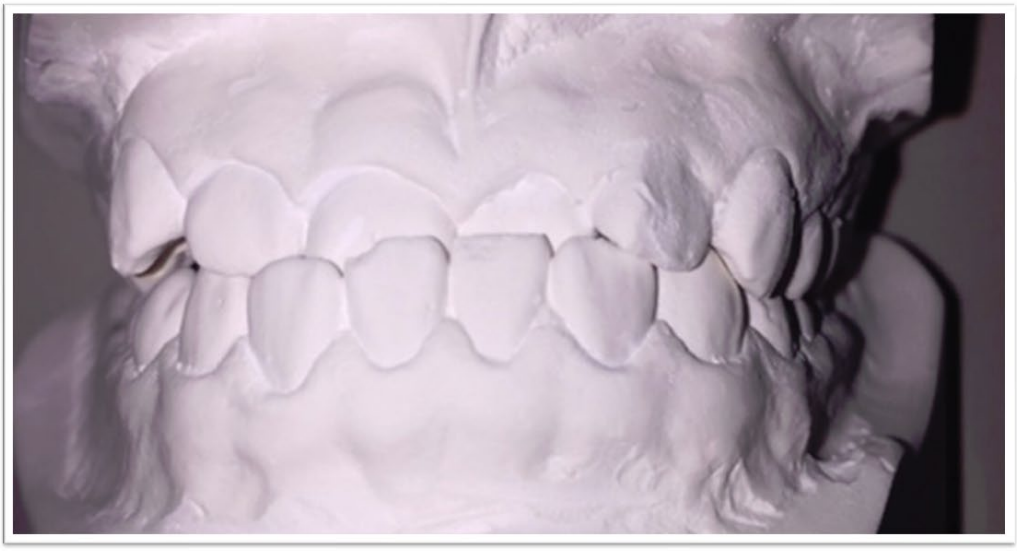
Bilateral Posterior Crossbite



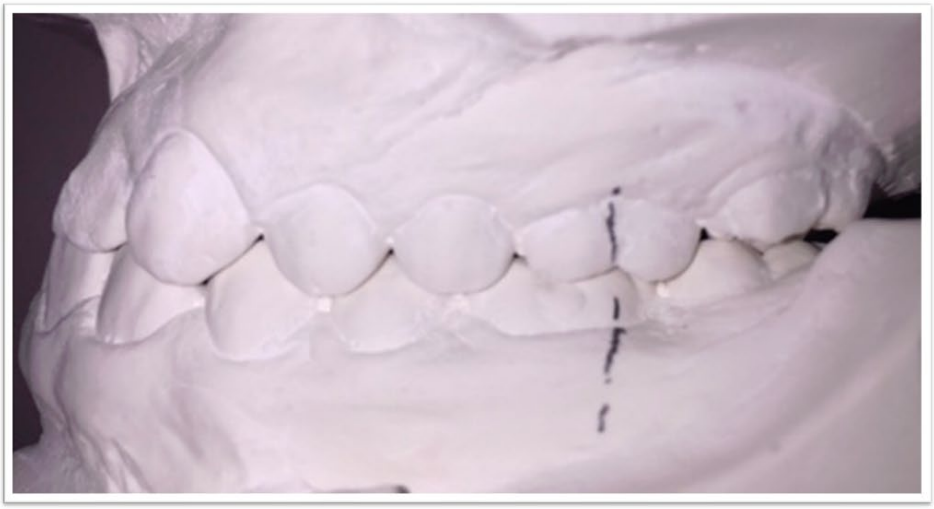
Labeling Models

- Diagnostic casts must be properly labeled on each cast (upper and lower)
  - Patient's first and last name
  - Medi-Cal Identification Number
  - Billing Provider Name
  - Billing Provider NPI

Case Study

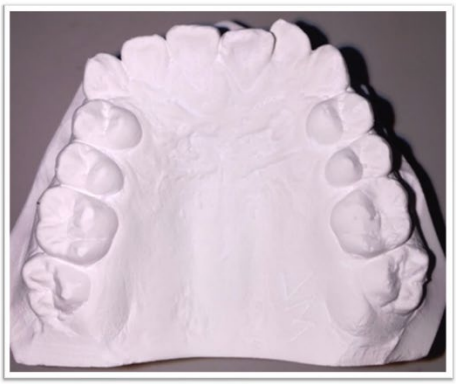


Case Study



Case Study

Case Study



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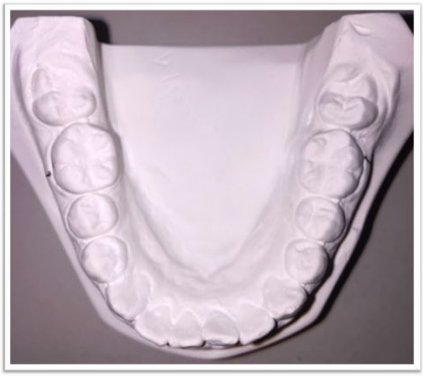

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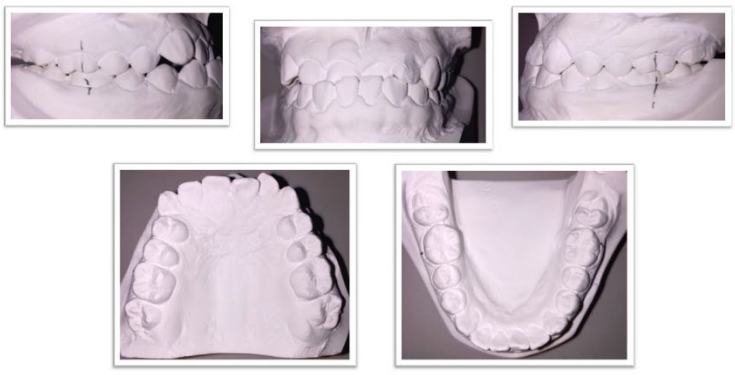

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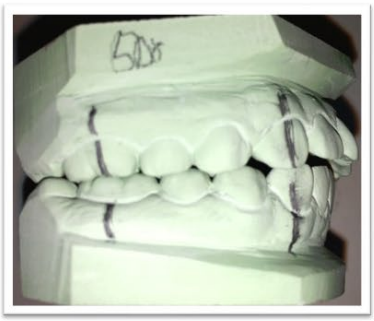
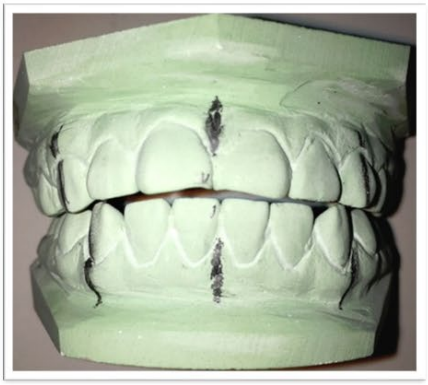
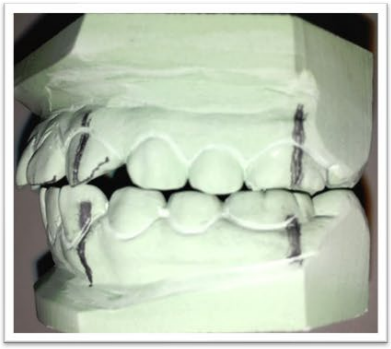

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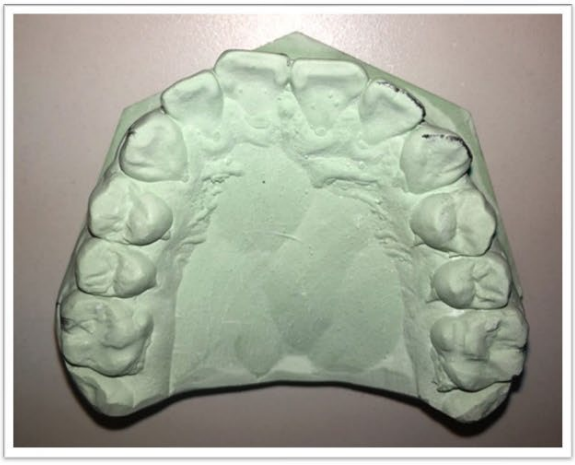
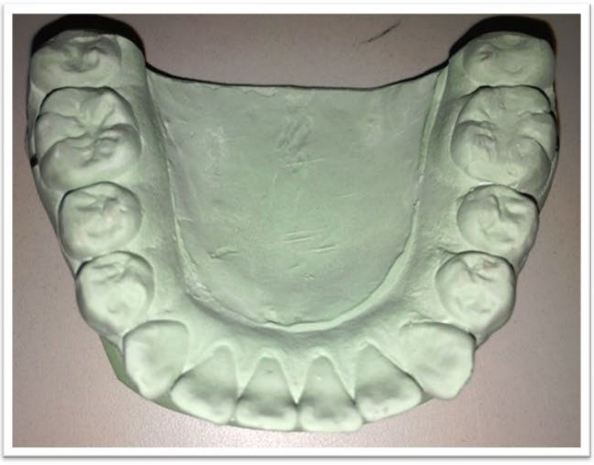

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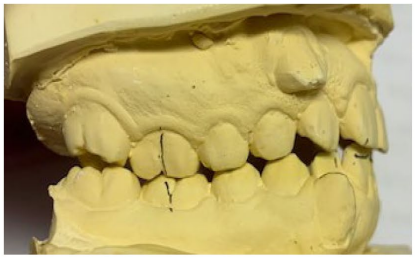
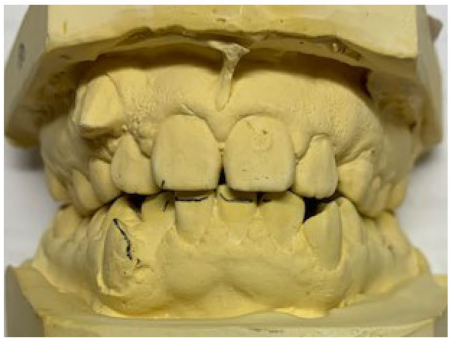
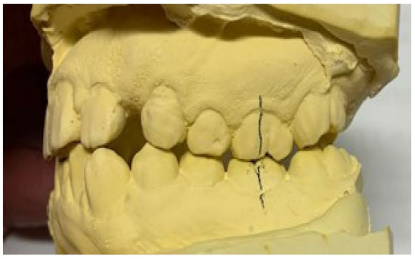
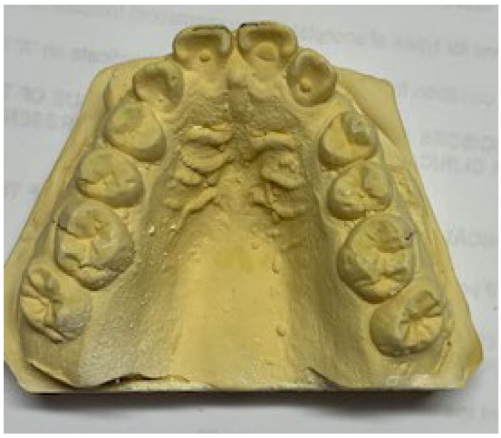
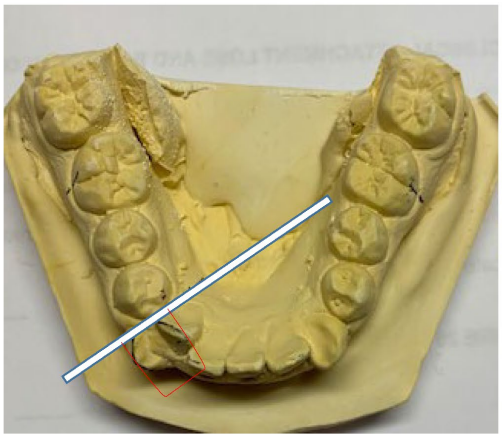
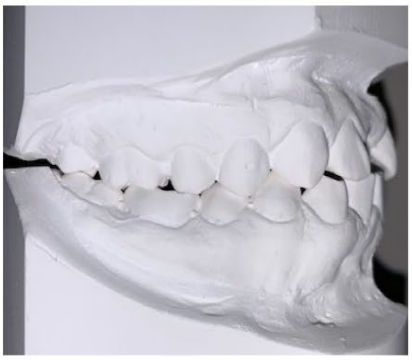
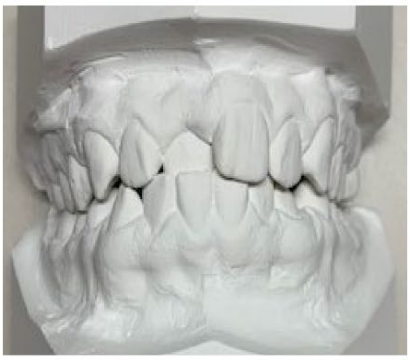
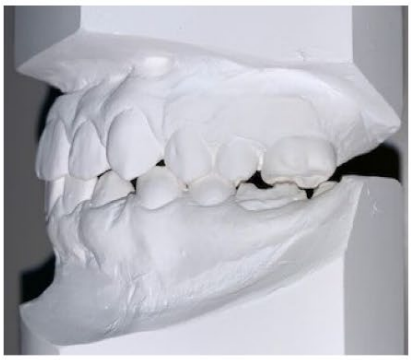




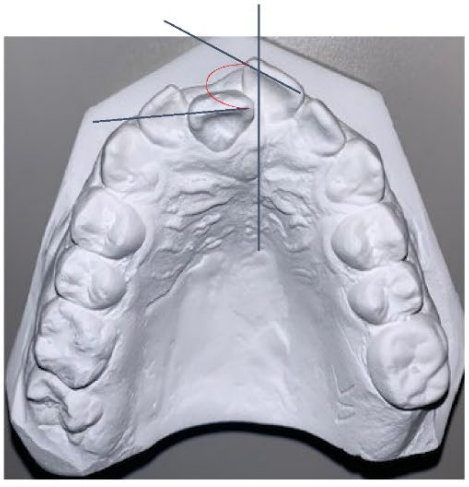
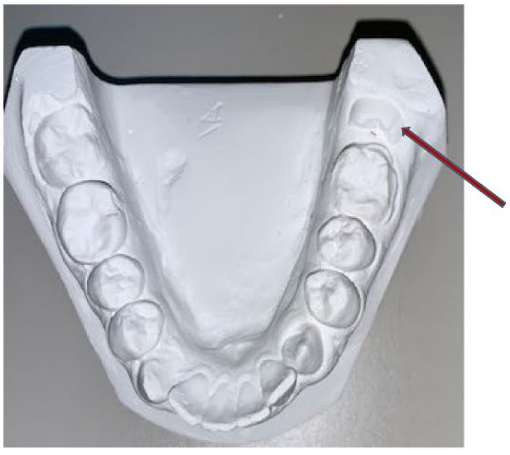
Case Study

Case Study

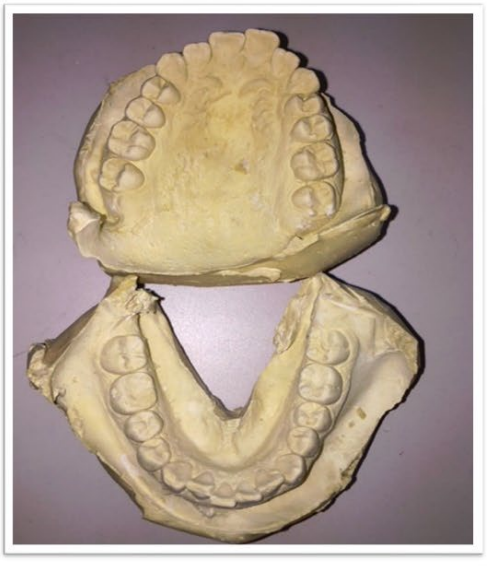




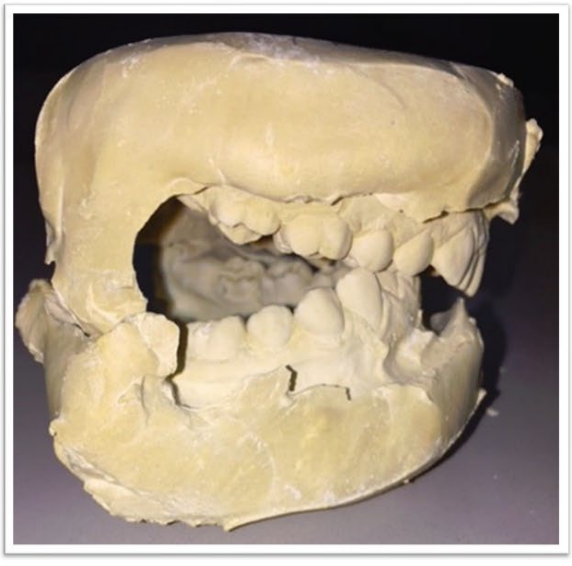
Case Study

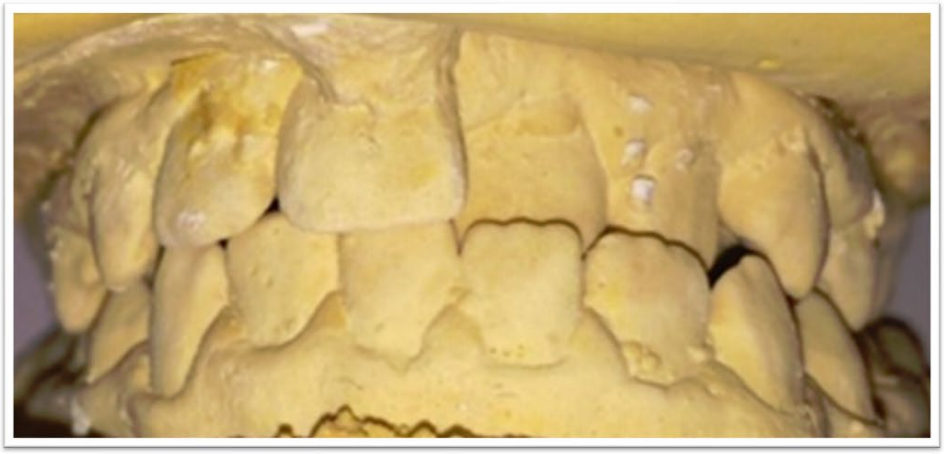
Model Trimmer

Model Trimmer

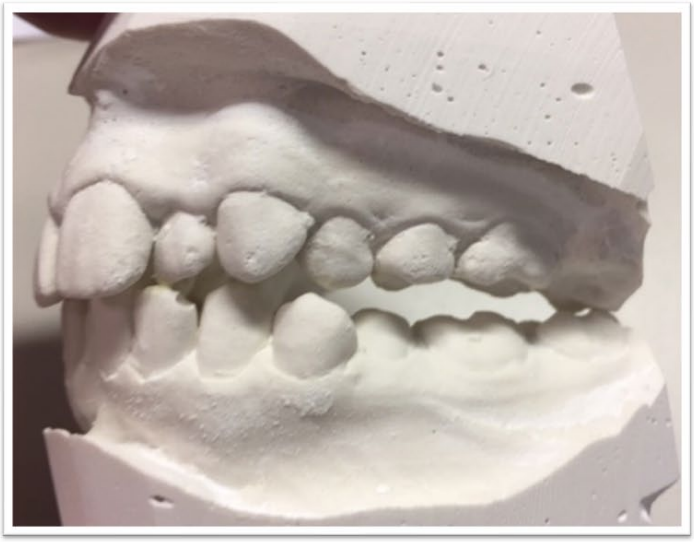




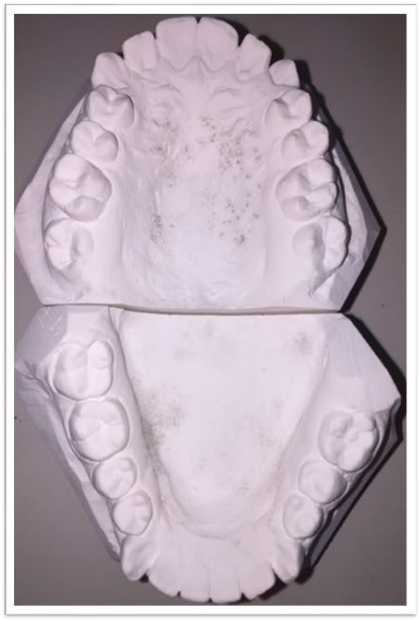
Remove Artifacts



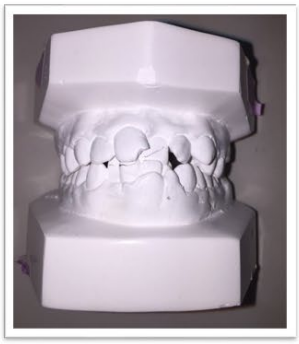
Casts Must Articulate

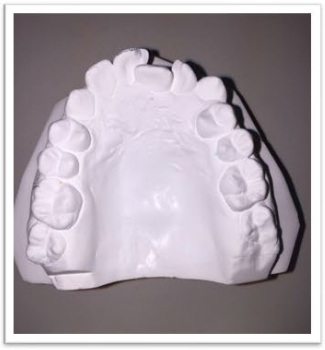


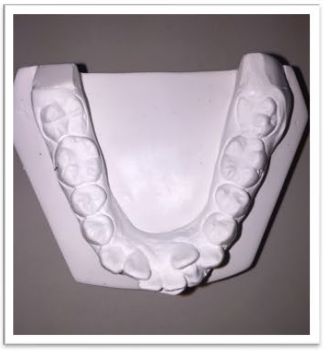
Allow Casts to Dry



No Artifacts







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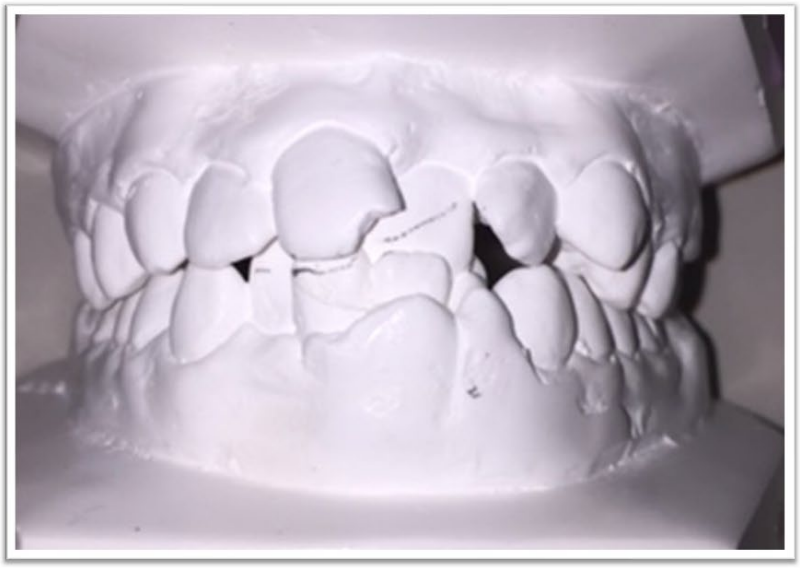
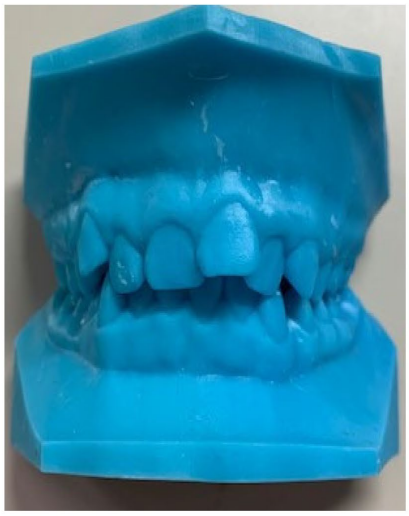
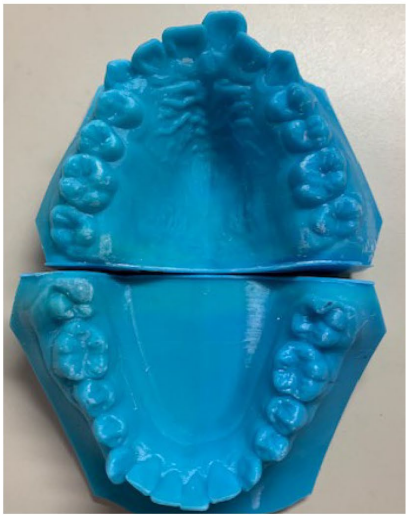


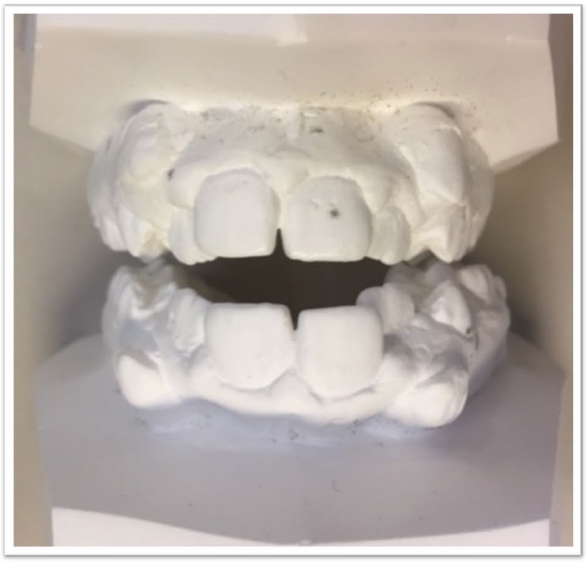
Wax Bites

Printed Casts

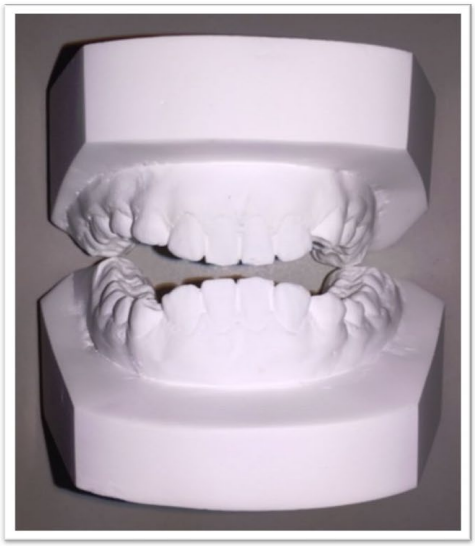




Efficiency



Efficiency



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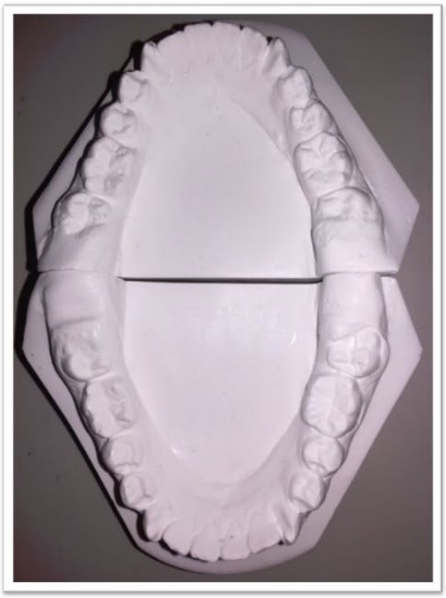
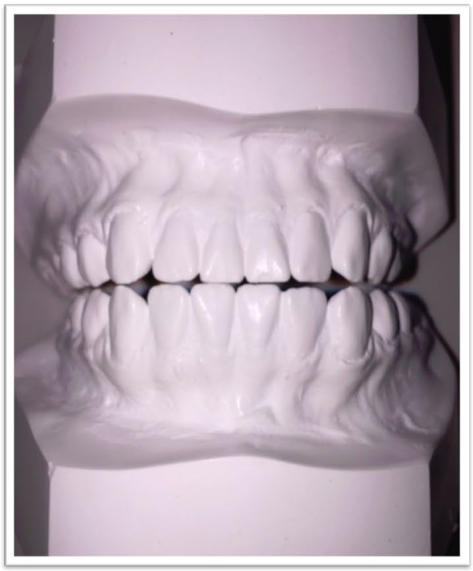


Efficiency



Step 2

Diagnostic Casts

Diagnostic Casts (Procedure D0470) are required documentation for all handicapping malocclusion and cleft palate treatment plan requests. Exception: If the member has a cleft palate that is not visible on diagnostic casts, casts are not required. However, photographs or documentation from a credentialed specialist must be submitted.

Cranio-facial anomalies cases do not require the submission of diagnostic casts for treatment plan requests but do require documentation from a credentialed specialist.

Casts must be of diagnostic quality. To meet diagnostic requirements, casts must be properly poured and adequately trimmed to allow placement into centric occlusion. No large voids or positive bubbles should be present. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

Additionally, diagnostic casts should be clearly labeled with proper identification so they can be matched with the correct TAR. This identification should clearly indicate the member's name, Client Index Number (CIN) or Benefits Identification Card (BIC) number, the billing provider’s name, and billing provider’s NPI. If the casts are received without identification, they will be destroyed.

Careful packaging will help ensure that the casts arrive at the Medi-Cal Dental program in good condition. The Medi-Cal Dental receives many broken and damaged casts due to poor packaging, which causes processing delays. Use a box that has sufficient packaging material (such as Styrofoam peanuts, shredded newspaper, bubble wrap, etc.) so that the casts will not be jarred or bumped during shipping. Also, place packaging materials between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for payment or the TAR for orthodontic treatment.

Only duplicate or second pour diagnostic casts should be sent to the Medi-Cal Dental. The casts will not be returned. Diagnostic casts of denied cases will be kept in the Medi-Cal Dental office for 30 days following a denial and up to one year off-site to enable a request for reevaluation.

Step 2

» If the member qualifies for orthodontia under the guidelines of the Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet, you may provide the next step:

- D0470 = Diagnostic Casts

Orthodontic Program Diagnostic Casts

» Are a benefit once for each phase of orthodontic treatment

» Will not be returned by the Medi-Cal Dental program

» Are payable only upon authorization of the orthodontic treatment plan

Orthodontic Program Diagnostic Casts

Submit Casts:

» That are properly trimmed and free of voids

» Be sure to mark centric, and send a bite registration or indicate markings of occlusion

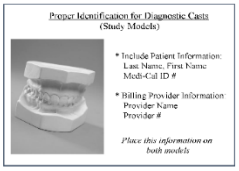
» Label both upper and lower casts clearly with patient and billing provider information

» Do not send Treatment Authorization Request (TAR) or Resubmission Turnaround Document (RTD) in the same package as casts

» Send only clean, dry casts

» Pack casts carefully

» Send casts approximately 10 days earlier than TAR



Step 3

Step 3

1. Submit a claim for the D0140 exam
2. Complete a TAR for the full orthodontic treatment plan
3. Attach the HLD Index Score Sheet to the TAR
4. Send claim and TAR together in the document mailing envelope
5. Send properly packed diagnostic casts separately

Claim Form Example

DO NOT WRITE IN THIS AREA

YY 018 1 00003

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 / HOW MANY?_____	11. CHECK IF ACCIDENT/INJURY? YES / EMPLOYMENT RELATED? YES	13. CHECK IF OTHER DENTAL COVERAGE: YES	14. MEDICARE DENTAL COVERAGE: YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF 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 x	

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 #: C1294B1539

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

EXAMINATION AND TREATMENT

26. TOOTH/ALTR 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 Limited Oral Evaluation	MM DD YY		D0140	50.00	1234567899
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED	50.00
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 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. The X-Ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

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)

Treatment Plan Authorization

The Treatment Authorization Request (TAR) for orthodontic services must include the complete orthodontic treatment plan: Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080), Periodic Orthodontic Treatment Visits (Procedure D8670), and Orthodontic Retention (Procedure D8680). Note: Cranio-facial anomalies cases may request Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6).

Include with the authorization request any necessary radiographs, such as a full mouth series (Procedure D0210) or panoramic film (Procedure D0330), and cephalometric head film and tracings (Procedure D0340). Indicate in the "quantity" field of the TAR form, the number of visits for active treatment (Procedure D8670) depending on the type of case and the phase of dentition. Also, indicate the “case type” and “phase of dentition” in the comments section (box 34). Use usual, customary, and reasonable (UCR) fees times the quantity to ensure accurate calculation of the Notice of Authorization (NOA.)

Attach the HLD Score Sheet to the TAR and send it to the address printed on the form. Diagnostic Casts should be properly packed and boxed and sent separately to the same address. Sending the casts approximately five days prior to sending the TAR will insure more expeditious handling at Medi-Cal Dental. Submission of the HLD Score Sheet and diagnostic casts (or documentation from a credentialed specialist) are required documentation to substantiate the treatment plan request.

The Medi-Cal Dental orthodontic consultant will evaluate the HLD Score Sheet and diagnostic casts or documentation together, to determine if the case qualifies for treatment under the Medi-Cal Dental guidelines for orthodontic services.

Treatment Authorization Request (TAR) Example

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.): Last, First	3. SEX: M X F	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. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?_____	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF 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?	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 X

19. BILLING PROVIDER NAME (LAST FIRST M.I.): Adams, James, DDS Inc.	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 X | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

Supporting documentation from a credentialed specialist may be substituted when Diag. Casts do not verify the condition for cleft palate or cranio-facial anomalies cases.

EXAMINATION AND TREATMENT

26. TOOTH/MLTR. ARCH./QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DA... PERFORMED	...UANTITY	PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Comprehensive Ortho Tx.			D8080	500.00	
		2 Periodic Ortho Tx Visits		08	D8670	1920.00	
U		3 Ortho Retention		01	D8680	500.00	
L		4 Ortho Retention		01	D8680	500.00	
		5 Full Mouth Series			D0210	75.00	
		6					
		7					
		8					
		9					
		10					

34. ...MENTS

CASE TYPE: Malocclusion - Permanent Dentition

HLD Score Sheet Attached / Diagnostic Casts Sent Separately

35. TOTAL FEE CHARGED	3495.00
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 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. The X-Ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

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)

Reevaluation of the Notice of Authorization (NOA)

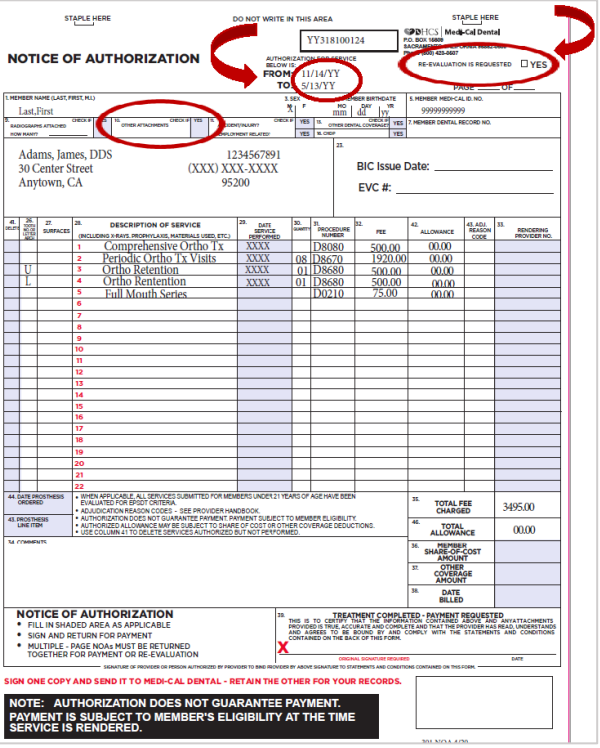
Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Medi-Cal Dental on or before the expiration date (within 180 days).

There are no reevaluations on "exploded" NOAs. An explanation of the term “exploded” NOAs is as follows: The TAR will include all requested orthodontic treatments, but when Medi-Cal Dental sends the NOAs, they will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- The first NOA will include the Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080) along with any radiographs that were requested on the original TAR.
- The remaining Treatment Visit NOAs (Procedure D8670) will be sent once per quarter, over the course of treatment.
- Then the orthodontic retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment.

Re-evaluation

- » May be requested on a denied NOA for the Orthodontic Treatment Plan only
- » Check the Reevaluation Box
- » Must be received by Medi-Cal Dental on or before the expiration date
- » Do submit HLD/additional documentation
- » Do not sign the NOA
- » NOA may only be submitted for reevaluation one time



STAPLE HERE

DO NOT WRITE IN THIS AREA

STAPLE HERE

NOTICE OF AUTHORIZATION

YY318100124

Medi-Cal Dental

RE-EVALUATION IS REQUESTED ☐ YES

FROM 11/14/YY

TO 5/13/YY

1. MEMBER NAME (LAST, FIRST, M.I.) Last,First

5. MEMBER BIRTHDATE MO DAY YR mm dd yy

6. MEMBER MEDI-CAL ID. NO. 9999999999

7. MEMBER DENTAL RECORD NO.

Adams, James, DDS
30 Center Street
Anytown, CA

1234567891
(XXX) XXX-XXXX
95200

23. BIC Issue Date: _____
EVC #: _____

28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	35. RENDERING PROVIDER NO.
1 Comprehensive Ortho Tx	XXXX		D8080	500.00	00.00		
2 Periodic Ortho Tx Visits	XXXX	08	D8670	1920.00	00.00		
U 3 Ortho Retention	XXXX	01	D8680	500.00	00.00		
L 4 Ortho Rentention	XXXX	01	D8680	500.00	00.00		
5 Full Mouth Series			D0210	75.00	00.00		

35. TOTAL FEE CHARGED 3495.00
44. TOTAL ALLOWANCE 00.00
36. MEMBER SHARE-OF-COST AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED

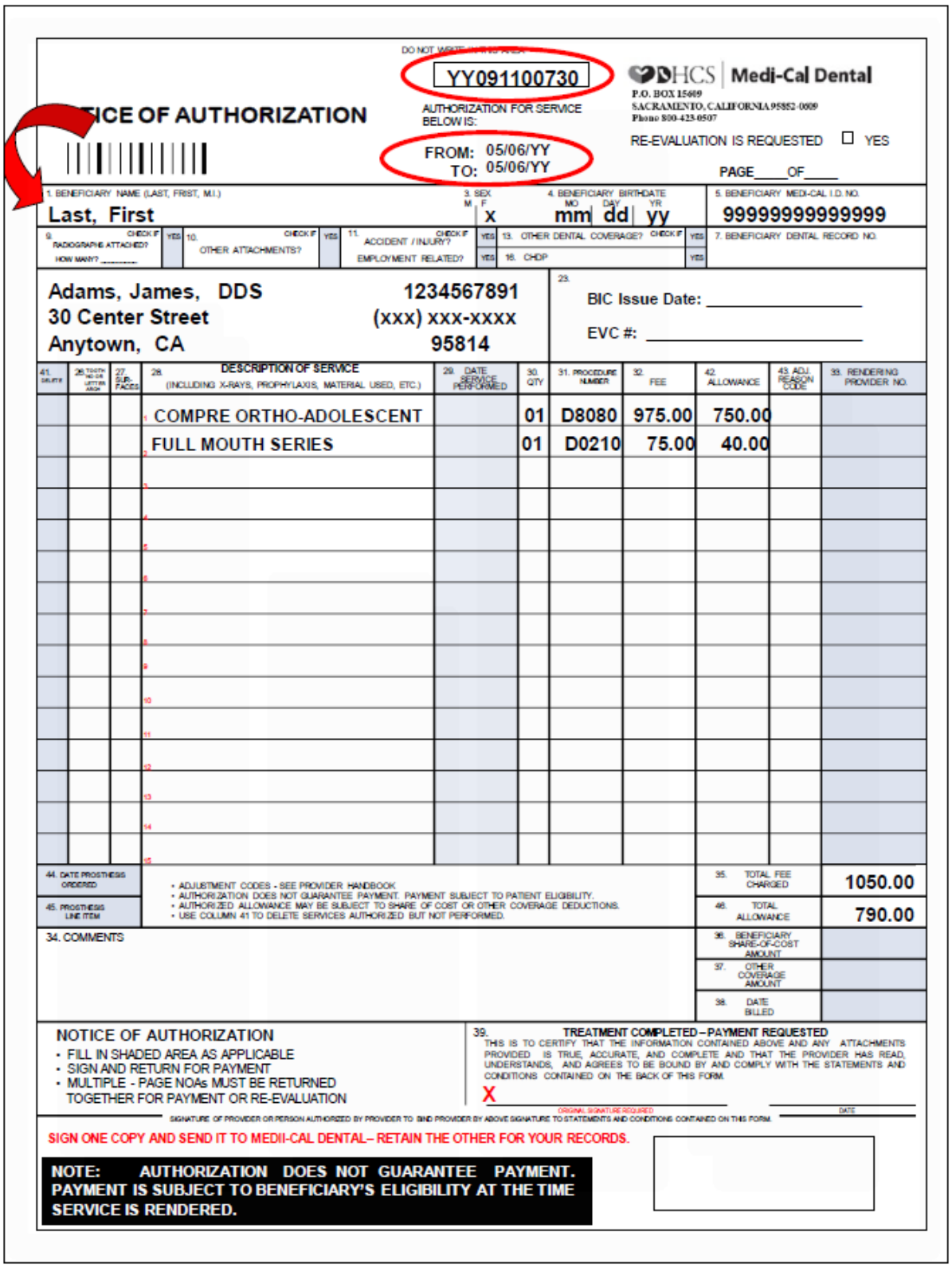
NOTICE OF AUTHORIZATION
- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. TREATMENT COMPLETED - PAYMENT REQUESTED

SIGN ONE COPY AND SEND IT TO MEDI-CAL DENTAL - 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.

Notice of Authorization (NOA) Example



DO NOT WRITE IN THIS AREA

YY091100730

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY
TO: 05/06/YY

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

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

NOTICE OF AUTHORIZATION

1. BENEFICIARY NAME (LAST, FIRST, M.I.): Last, First
3. SEX M / F: x
4. BENEFICIARY BIRTHDATE MO / DAY / YR: mm / dd / yy
5. BENEFICIARY MEDI-CAL I.D. NO.: 99999999999999
9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY? _____ YES
10. CHECK IF OTHER ATTACHMENTS? YES
11. CHECK IF ACCIDENT / INJURY? EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? CHECK IF YES
16. CHDP YES
7. BENEFICIARY DENTAL RECORD NO.

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 AREA	27. SUB-PACES	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.
			1 COMPRE ORTHO-ADOLESCENT		01	D8080	975.00	750.00		
			2 FULL MOUTH SERIES		01	D0210	75.00	40.00		
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED
45. PROSTHESIS LINE ITEM

- 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: 1050.00
36. TOTAL ALLOWANCE: 790.00
38. 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.

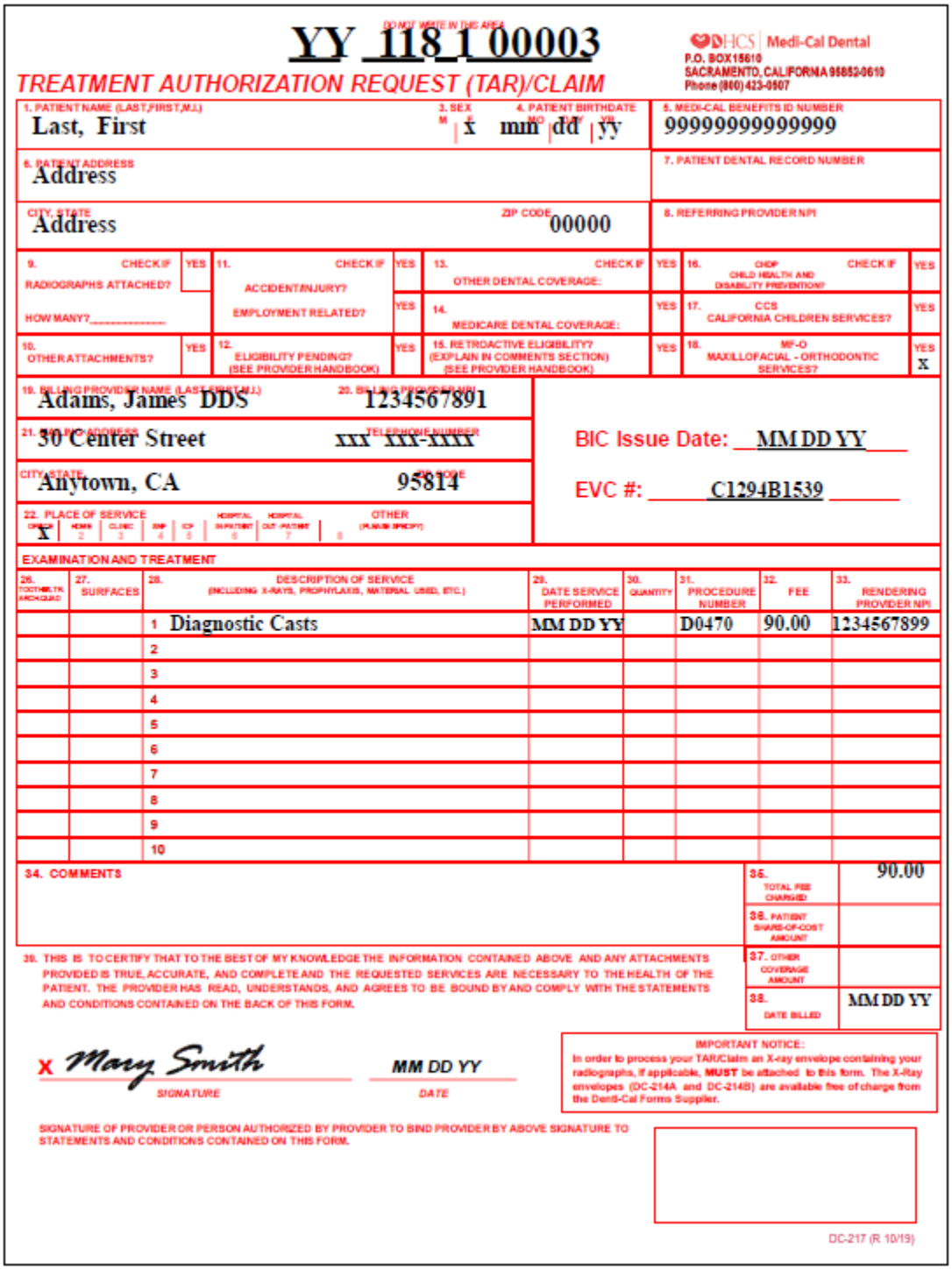
X _____ _____
ORIGINAL SIGNATURE REQUIRED DATE
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

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

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

Step 4

- Submit a claim for diagnostic casts



DO NOT WRITE IN THIS AREA

YY 118 1 00003

DHCS Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95853-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.) Last, First	3. SEX M x F	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. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?_____	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF	YES
			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 x

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 x; HOME 2; CLINIC 3; SNF 4; ICF 5; HOSPITAL (IN PATIENT) 6; HOSPITAL (OUT-PATIENT) 7; OTHER (PLEASE SPECIFY) 8	BIC Issue Date: MM DD YY EVC #: C1294B1539

EXAMINATION AND TREATMENT

26. TOOTH NO., LTR. A-K, QUAD/ARCH/JAW	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 Diagnostic Casts	MM DD YY		D0470	90.00	1234567899
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED	90.00
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 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. The X-Ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

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)

Orthodontic Treatment Procedures

Payment for Procedure D8670 will be made once per calendar quarter per provider for the active phase of orthodontic treatment. A calendar quarter is defined as: January – March, April – June, July – September, and October – December. Submit one NOA containing *only one* date of service for each quarter of treatment (regardless of the number of actual treatment visits within that quarter.) Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080.)

The active phase of orthodontic treatment will be authorized for a set number of visits depending on the case type. Some treatment plans may take longer than originally anticipated due to the severity of the case. It is possible to request additional quarterly treatment visits. The request for additional treatment will require submission of a new TAR requesting; any visits left to be completed from the original authorization, plus additional visits that will complete the case, plus the retainers. If there are any outstanding NOAs from the original authorization, please attach them to the new TAR and request that they be deleted. Written documentation to justify the need for additional orthodontic treatment and progress photos must be submitted with the new TAR.

When the new TAR is authorized by Medi-Cal Dental, a series of NOAs confirming the authorization will be mailed. The NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. Use the *new* NOAs for billing purposes. Each quarter when services are provided, submit one NOA to Medi- Cal Dental for payment. Bill only one adjustment per NOA. Before submitting the NOA to Medi-Cal Dental, indicate the date of service and sign the NOA.

If orthodontic treatment should be accomplished in less time than originally authorized, document this on the NOA for retainers and attach a progress photo when submitting for payment. Attach any unused NOAs for quarterly visits marking them for deletion.

Time limitations for payment of NOAs are as follows:

- 100% of the Schedule of Maximum Allowances (SMA), when received no later than 6 months from the end of the month in which the service was performed.
- 75% of the SMA when received no later than 7 to 9 months from the end of the month in which the service was performed.
- 50% of the SMA when received no later than 10 to 12 months from the end of the month in which the service was performed

Notices of Authorization for payment will be processed in accordance with general Medi-Cal Dental billing policies and criteria requirements for orthodontic services. **Please remember that authorization does not guarantee payment. Payment is always subject to member's eligibility.**

Exploded NOAs from Medi-Cal Dental Example

DO NOT WRITE IN THIS AREA

YY126170013

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY
TO: 05/06/YY

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

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, 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? HOW MANY?	10. OTHER ATTACHMENTS?	11. ACCIDENT / INJURY? EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE?	16. CHDP	7. BENEFICIARY DENTAL RECORD NO.
CHECK IF YES	CHECK IF YES	CHECK IF YES	CHECK IF YES	CHECK IF 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 AREA	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.
			COMPRE ORTHO-ADOLESCENT		01	D8080	975.00	750.00		
			FULL MOUTH SERIES		01	D0210	75.00	40.00		

44. DATE PROSTHESIS ORDERED	• 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	1050.00
45. PROSTHESIS LINE ITEM		46. TOTAL ALLOWANCE	790.00
34. COMMENTS		36. BENEFICIARY SHARE-OF-COST AMOUNT	
		37. OTHER COVERAGE AMOUNT	
		38. DATE BILLED	

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

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 BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

DO NOT WRITE IN THIS AREA

YY127170001

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY
TO: 05/06/YY

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

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, 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? HOW MANY?	10. OTHER ATTACHMENTS?	11. ACCIDENT / INJURY? EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE?	16. CHDP	7. BENEFICIARY DENTAL RECORD NO.
CHECK IF YES	CHECK IF YES	CHECK IF YES	CHECK IF YES	CHECK IF YES	

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

23. BIC Issue Date: mm/dd/yy
EVC #:

41. DELETE	26. TOOTH NO. OR LETTER AREA	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.
			PERIODIC ORTHO TRMT VISIT		01	D8670	300.00	210.00		1234567899

44. DATE PROSTHESIS ORDERED	• 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	300.00
45. PROSTHESIS LINE ITEM		46. TOTAL ALLOWANCE	210.00
34. COMMENTS		36. BENEFICIARY SHARE-OF-COST AMOUNT	
		37. OTHER COVERAGE AMOUNT	
		38. DATE BILLED	

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

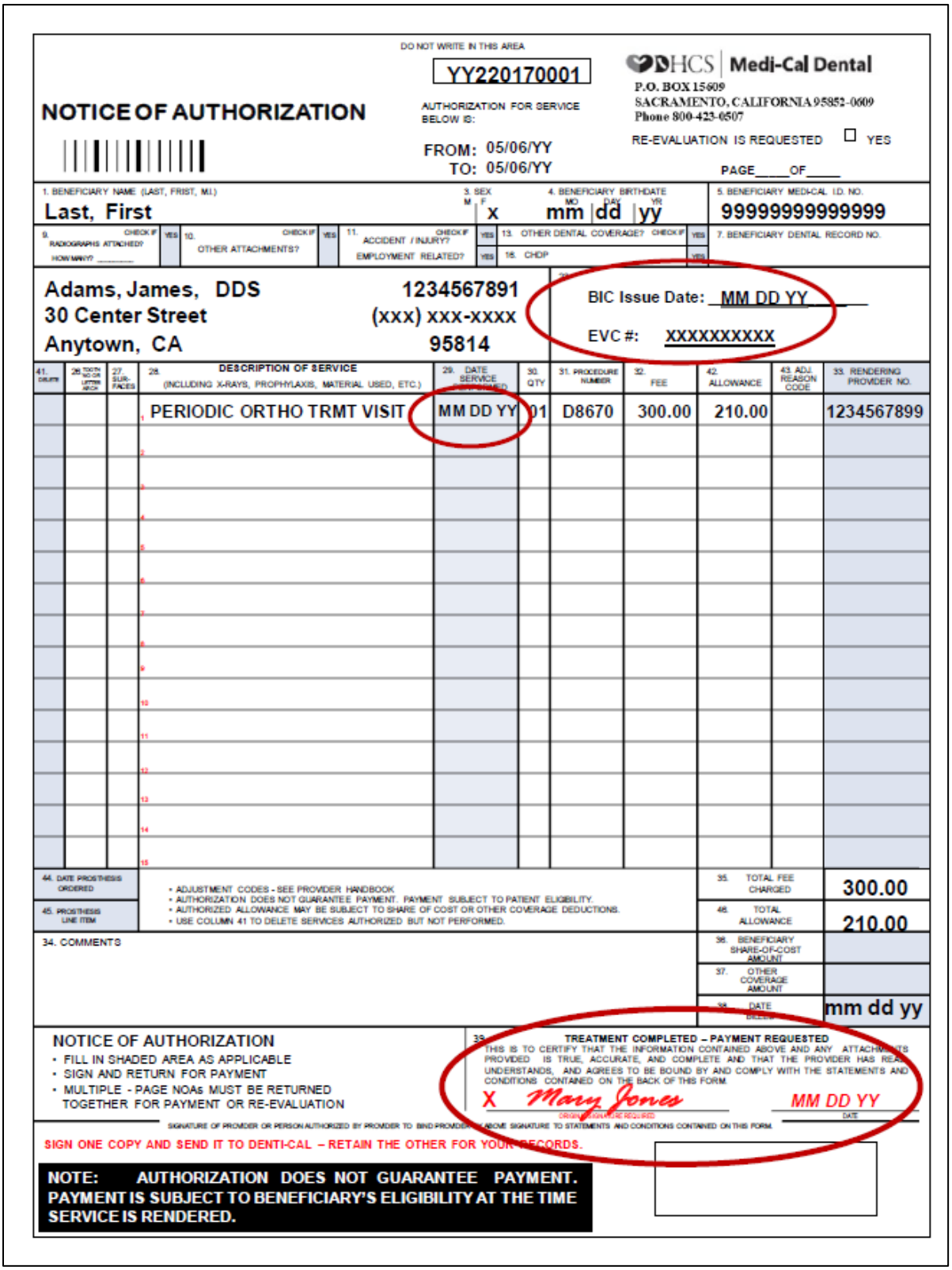
39. **TREATMENT COMPLETED – PAYMENT REQUESTED**
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK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

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

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 BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

Notice of Authorization (NOA) Example



DO NOT WRITE IN THIS AREA

YY220170001

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY
TO: 05/06/YY

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

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, 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? HOW MANY?	10. OTHER ATTACHMENTS?	11. ACCIDENT / INJURY? EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE?	16. CHDP	7. BENEFICIARY DENTAL RECORD NO.
YES	YES	YES	YES	YES	

Adams, James, DDS
30 Center Street
Anytown, CA

1234567891
(xxx) xxx-xxxx
95814

BIC Issue Date: MM DD YY

EVC #: XXXXXXXXXX

41. DRUPE	28. TOOTH NO. OR LETTER AREA	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE RENDERED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1 PERIODIC ORTHO TRMT VISIT	MM DD YY	01	D8670	300.00	210.00		1234567899
			2							
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- 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	300.00
46. TOTAL ALLOWANCE	210.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	mm dd yy

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**

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X Mary Jones — MM DD YY

ORIGINAL SIGNATURE REQUIRED — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER TO 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 BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

TAR for Extensions Example

DO NOT WRITE IN THIS AREA

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.)	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm dd yy	999999999999999
6. PATIENT ADDRESS: Address			7. PATIENT DENTAL RECORD NUMBER
CITY, STATE: Address		ZIP CODE: 00000	8. REFERRING PROVIDER NPI

9. RADIOGRAPHS ATTACHED? HOW MANY?_____	CHECK IF 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 x

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

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

EXAMINATION AND TREATMENT

26. TOOTH/ILTR. 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 Periodic Ortho Treatment Visits		4	D8670	800.00	
U		2 Retainer			D8680	250.00	
L		3 Retainer			D8680	250.00	
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

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

NOA (Deleting Old NOAs for New Treatment Plan) Example

DO NOT WRITE IN THIS AREA

YY127170003

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

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:
FROM: 05/06/YY
TO: 05/06/YY

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF_____

1. BENEFICIARY NAME (LAST, FRIST, 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? HOW MANY? _____	CHECK IF YES	10. OTHER ATTACHMENTS?	CHECK IF YES	11. ACCIDENT / INJURY? EMPLOYMENT RELATED?	CHECK IF YES	13. OTHER DENTAL COVERAGE?	CHECK IF YES
					YES	16. CHDP	YES

7. BENEFICIARY DENTAL RECORD NO.

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

23. BIC Issue Date: _____
EVC #: _____

41. DELETE	26. TOOTH NO./QUADRANT LETTER ARCH	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.
			PERIODIC ORTHO TRMT VISIT		01	D8670	300.00	210.00		
			2							
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED
45. PROSTHESIS LINE ITEM

- 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	300.00
46. TOTAL ALLOWANCE	210.00
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 MEDI-CAL DENTAL – RETAIN THE OTHER FOR YOUR RECORDS.

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

D8696 = Repair of Orthodontic Appliances-Maxillary
D8697 = Repair of Orthodontic Appliances-Mandibular

- Does not require prior authorization except for transfer patients, which shall include photographs
- Requires an arch code
- The need must be documented with:
  - Type of appliance and a description of the repair
- A benefit once per appliance for patients under the age of 21
- Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires

D8698 = Re-Cement or Re-Bond Fixed Retainer-Maxillary
D8699= Re-Cement or Re-Bond Fixed Retainer-Mandibular

- This procedure does not require prior authorization
- Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
- Requires an arch code
- A benefit for patients under the age of 21 once per provider
- Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item)

D8701 = Repair of Fixed Retainer, Includes Reattachment-Maxillary
D8702 = Repair of Fixed Retainer, Includes Reattachment-Mandibular

- This procedure does not require prior authorization except for transfer members which shall include photographs
- Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair
- Requires an arch code
- A benefit:
  - For members under the age of 21
  - Once per appliance
- Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires

D8703 = Replacement of Lost or Broken Retainer-Maxillary
D8704 = Replacement of Lost or Broken Retainer-Mandibular

- This procedure does not require prior authorization except for transfer members which shall include photographs
- Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable
- Requires an arch code
- A benefit for members under of 21, once per arch, only within 24 months following the date of service of orthodontic retention (D8680)

Transfer Cases

» Transferring from another Medi-Cal Dental provider:

- Submit new TAR for remaining treatment plan
- Attach letter from parent/legal guardian requesting deletion of previous provider's authorization

» Transferring from a Non Medi-Cal Dental provider:

- Submit new TAR for remaining treatment plan
- Send original diagnostic casts and progress photos, or
- Progress casts and current HLD Score Sheet

Billing Limitations

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

» Authorization DOES NOT guarantee payment

» Payment is ALWAYS subject to patient eligibility

Resubmission Turnaround Document (RTD)

Medi-Cal Dental reviews each orthodontic claim, TAR and NOA to ensure that all the required information is present and correct. If an item has been omitted or is incorrect, the Medi-Cal Dental will issue an RTD. The RTD is a computer-generated form sent to request missing or additional information. This information must be received before the document can be processed.

Section "A" of the RTD lists the error(s) found on the original document and indicates the time limitation for response. Section "B" of the form is used to enter the requested information. After completion, sign and date the form, detach section "B" and return it to the Medi-Cal Dental program for processing. Retain section "A" of the RTD for the office records. Make certain to return the RTD promptly to Medi-Cal Dental. **The provider has 45 days in which to respond**. If the RTD is not returned within the time indicated, the Medi-Cal Dental program must deny the original document. Refer to the Provider Handbook, Section 6: Forms for complete instructions.

Specific to the orthodontic program, an RTD will be received 12 months into treatment inquiring if treatment is continuing. You must respond to the RTD within the time allowed, or any further treatment will be denied. In the case of a denial, a new TAR must be submitted requesting the remaining treatment plan. Procedures required on the new TAR are as follows:

1. Procedure D8670 (Periodic Ortho Treatment Visits x appropriate # of quarterly visits for case type requested)
2. Procedure D8680 x 1 (upper retainer)
3. Procedure D8680 x 1 (lower retainer)

Resubmission Turnaround Document (RTD) Example

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

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 DENTI-CAL. 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 PROVIDER HANDBOOK FOR FURTHER INFORMATION.

MEDI-CAL PROVIDER NO.

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

1234567891

NOTICE — PAGE 01 OF PAGES 01

RTD ISSUE DATE: MM DD YY — RTD DUE DATE: MM DD YY

PATIENT NAME	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.
Last, First	XXXXXX999D			450.00	YY283170403

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		39		N		99	

A

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

RETAIN THIS PORTION
DETACH ALONG THIS PERFORATION

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY

DENTI-CAL USE ONLY

DCN: YY283170403 — CLAIM TYPE: T — PAGE: 01 OF — PAGES: 01

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

BILLING PROVIDER NAME: Adams, James, DDS
MEDI-CAL PROVIDER NUMBER: 1234567891
PATIENT NAME: Last, First
PATIENT MEDI-CAL I.D. NUMBER: XXXXXX999D

This is to certify that the corrected information 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 the 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.

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

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
N	39		99	A

B

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

RTD For Continuing Ortho Treatment Example

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY

DENTI-CAL USE ONLY

DCN: YY283170403 — CLAIM TYPE: T — PAGE: 01 OF — PAGES: 01

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

BILLING PROVIDER NAME: Adams, James, DDS
MEDI-CAL PROVIDER NUMBER: 1234567891
PATIENT NAME: Last, First
PATIENT MEDI-CAL I.D. NUMBER: XXXXXX999D

This is to certify that the corrected information 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 the 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.

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

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
N	39		99	A

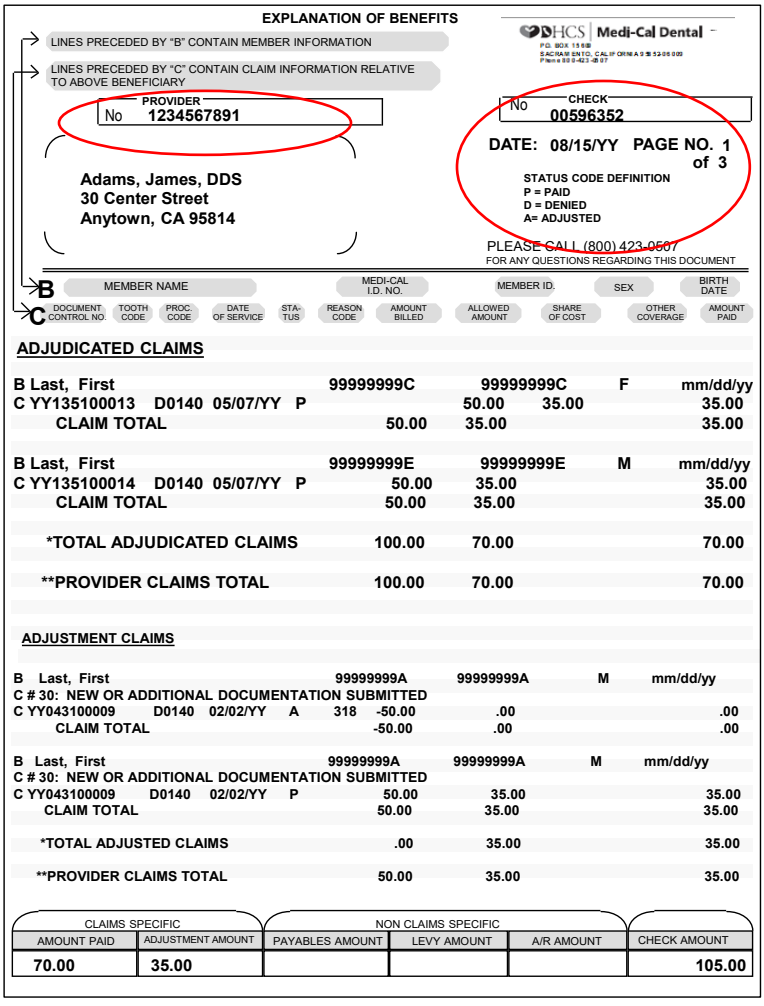
B

Leave Blank

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

Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement which accompanies each Medi-Cal Dental payment received. The EOB lists all paid, modified and disallowed claims which have been processed during a payment cycle, as well as adjusted claims, and claims and TARs which have remained "in process" for more than 18 days. It also shows non-claims specific information, such as payable/receivable amounts and levy deductions. The EOB is an easy-to-read, comprehensive document which provides important payment information. Refer to the Provider Handbook, Section 6: Forms for a detailed explanation.



EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

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

PROVIDER No 1234567891

CHECK No 00596352

DATE: 08/15/YY 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 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

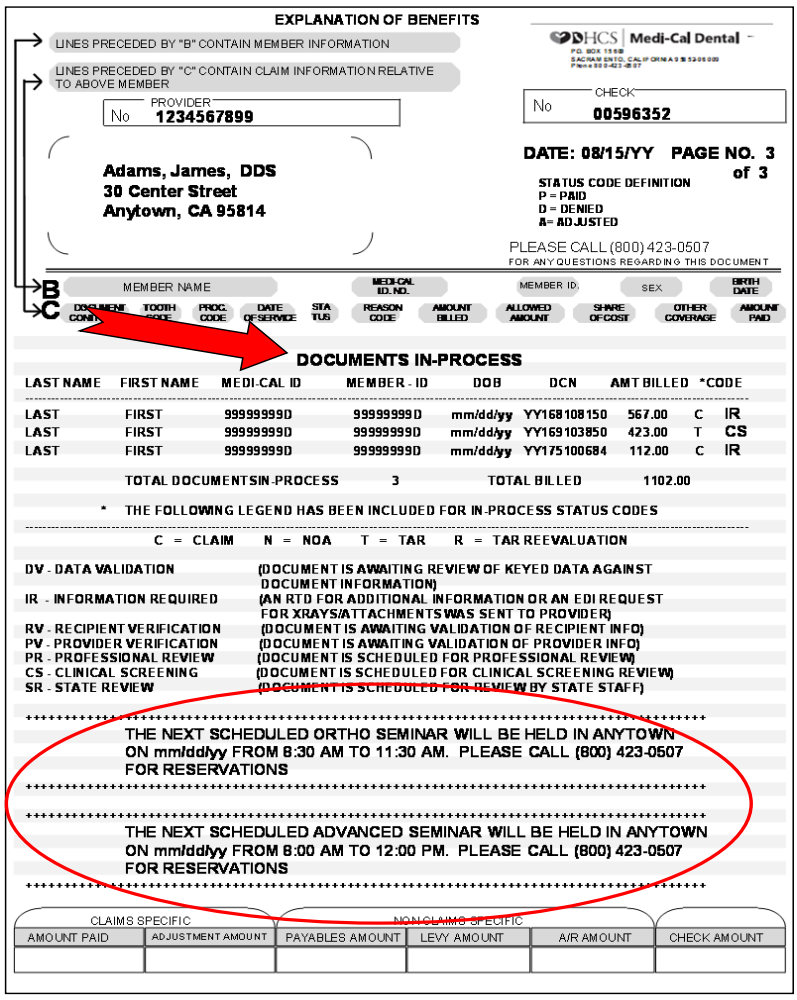
ADJUDICATED CLAIMS

B Last, First				99999999C	99999999C		F			mm/dd/yy
C YY135100013	D0140	05/07/YY	P		50.00	35.00				35.00
CLAIM TOTAL				50.00	50.00	35.00				35.00
B Last, First				99999999E	99999999E		M			mm/dd/yy
C YY135100014	D0140	05/07/YY	P	50.00	35.00					35.00
CLAIM TOTAL				50.00	35.00					35.00
*TOTAL ADJUDICATED CLAIMS				100.00	70.00					70.00
**PROVIDER CLAIMS TOTAL				100.00	70.00					70.00

ADJUSTMENT CLAIMS

B Last, First				99999999A	99999999A		M			mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C YY043100009	D0140	02/02/YY	A	318	-50.00	.00				.00
CLAIM TOTAL					-50.00	.00				.00
B Last, First				99999999A	99999999A		M			mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C YY043100009	D0140	02/02/YY	P		50.00	35.00				35.00
CLAIM TOTAL					50.00	35.00				35.00
*TOTAL ADJUSTED CLAIMS					.00	35.00				35.00
**PROVIDER CLAIMS TOTAL					50.00	35.00				35.00

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
70.00	35.00				105.00



EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

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

PROVIDER No 1234567899

CHECK No 00596352

DATE: 08/15/YY PAGE NO. 3 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 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	99999999D	99999999D	mm/dd/yy	YY175100684	112.00	C	IR

TOTAL DOCUMENTS IN-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 ORTHO 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

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

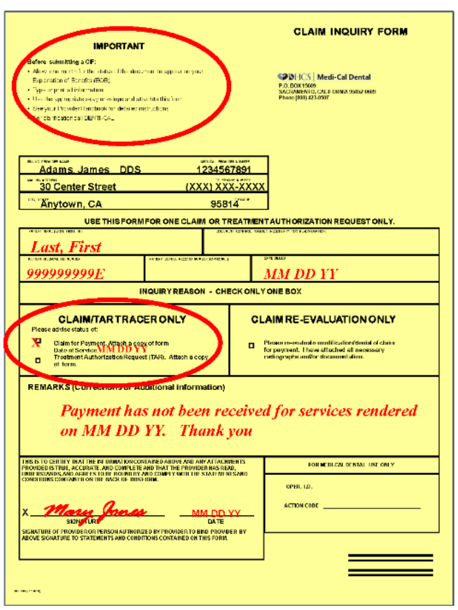
Claim Inquiry Form (CIF)

Medi-Cal Dental has developed a form to simplify the provider inquiry and response process. The form is called the Claim Inquiry Form (CIF). This form provides an automated, quick response to any inquiries.

The first use for the CIF is to inquire about the status of a claim or TAR. The provider will receive a written response from Medi-Cal Dental called a Claim Inquiry Response (CIR). The second use for the CIF is to request reevaluation of a modified or denied claim or procedure that appears on the EOB. Always use a separate CIF for each inquiry. Complete all applicable areas on the CIF, including the provider number and DCN, and attach all related documentation. CIFs must be submitted within six months from the date of the EOB when requesting a reevaluation of a denied claim or procedure. Do not use a CIF to request a first-level appeal, or to request the reevaluation of a denied treatment plan on the NOA.

Inquiries using the CIF process are limited to only those reasons indicated on the form. Any other type of inquiry or request should be handled by telephone or written correspondence. Before submitting a CIF, use the toll-free line, (800) 423-0507 for any inquiries.

Claim Tracer



IMPORTANT

CLAIM INQUIRY FORM

Medi-Cal Dental

Adams, James DDS 1234567891
30 Center Street (XXX) XXX-XXXX
Anytown, CA 95814

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

Last, First

999999999E MM DD YY

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

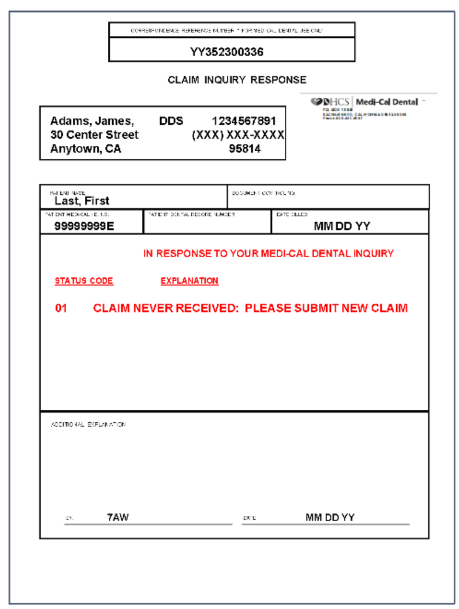
CLAIM RE-EVALUATION ONLY

REMARKS

Payment has not been received for services rendered on MM DD YY. Thank you

X Mary Jones MM DD YY

Claim Inquiry Response (CIR)



YY352300336

CLAIM INQUIRY RESPONSE

Medi-Cal Dental

Adams, James, DDS 1234567891
30 Center Street (XXX) XXX-XXXX
Anytown, CA 95814

Last, First

99999999E MM DD YY

IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY

STATUS CODE EXPLANATION

01 CLAIM NEVER RECEIVED: PLEASE SUBMIT NEW CLAIM

7AW MM DD YY

CIF Re-Revaluation

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 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	1234567891
MAILING ADDRESS	TELEPHONE NUMBER
30 Center Street	(XXX) XXX-XXXX
CITY, STATE	ZIP CODE
Anytown, CA	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	*YY280100009*

PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
999999999E		

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

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

REMARKS (Corrections or Additional information)

Patient is now eligible for services rendered on MM DD YY. EVC# C174860012

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 *Mary Jones* _____ MM DD YY

SIGNATURE DATE

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

FOR MEDII-CAL DENTAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 10/19)

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 Example

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental
P.O. BOX 15630
SACRAMENTO, CALIFORNIA 95853-0630
Phone 800-423-0507

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: 08/15/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					

	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
C											

ADJUSTMENT CLAIMS

B Last, First 999999999D 99999999D M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 0202YY A 318 -50.00 .00 .00
CLAIM TOTAL -50.00 .00 .00

B Last, First 999999999D 99999999D M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 0202YY P 50.00 35.00 35.00
CLAIM TOTAL 50.00 35.00 35.00

***TOTAL ADJUSTED CLAIMS .00 35.00 35.00**

****PROVIDER CLAIMS TOTAL 100.00 35.00 35.00**

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
100.00	35.00				35.00

Additional Ortho Information

- Orthodontic procedures fee schedule
- Commonly used acronyms
- Orthodontic adjudication reason codes
- Phone numbers and other services
- CCS Information

Medi-Cal Dental Fee Schedule for Orthodontic Services

Malocclusion, Cleft Palate and Cranio-facial Anomalies Cases		
		Maximum Allowance
D0140	Limited Oral Evaluation - All Case Types *(Initial Orthodontic Examination and completion of the Handicapping Labio Lingual Deviation (HLD) Index California Modification Score Sheet)*	35.00
D0470	Diagnostic Casts - All Case Types	75.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition - All Case Types *(Includes workup, photos, banding & materials)*	
	Malocclusion Case – Permanent Dentition	750.00
	Cleft Palate Case Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	925.00
	Craniofacial Case Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	1000.00
D8210	Removable appliance therapy	245.00
D8220	Fixed appliance therapy	245.00
D8660	Pre-Orthodontic Treatment Visit *(for Cranio-facial Anomalies Cases <u>Only</u>)*	50.00
D8670	Periodic Orthodontic Treatment Visits - All Case Types	
	Malocclusion Case (8 quarterly visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	210.00
	Cleft Palate Case <u>Primary Dentition</u> (4 quarterly visits maximum – Up to 2 additional quarters may be authorized after initial phase of treatment)	125.00
	<u>Mixed Dentition</u> (5 quarterly visits maximum – Up to 3 additional quarters may be authorized after initial phase of treatment)	140.00
	<u>Permanent Dentition</u> (10 quarterly visits maximum – Up to 5 additional quarters may be authorized after initial phase of treatment)	300.00

	Cranio-facial Case Mixed Dentition (5 quarterly visits maximum – Up to 3 quarters may be authorized after initial phase of treatment)	140.00
	Permanent Dentition (8 visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	300.00
D8680	Orthodontic Retention - All Case Types *(Includes retainers & all adjustments)*	244.00
D8695	Removal of Fixed Orthodontic Appliance(s) – other than at conclusion of treatment	50.00
D8696	Repair of orthodontic appliance – maxillary	50.00
D8697	Repair of orthodontic appliance – mandibular	50.00
D8698	Re-cement or re-bond fixed retainer- maxillary	30.00
D8699	Re-cement or re-bond fixed retainer- mandibular	30.00
D8701	Repair of fixed retainers, includes reattachment- maxillary	50.00
D8702	Repair of fixed retainers, includes reattachment- mandibular	50.00
D8703	Replacement of lost or broken retainer- maxillary	200.00
D8704	Replacement of lost or broken retainer- mandibular	200.00
D8999	Band Removal *(per arch – no further treatment being provided)* Not a benefit to the original provider, requires documentation.	By Report

Acronyms

Acronym	Definition
ARC	Adjudication Reason Codes
ASL	American Sign Language
AEVS	Automated Eligibility Verification System
BIC	Benefits Identification Card
CCR	California Code of Regulations
CDA	California Dental Association
CCS	California Children's Services
CIF	Claim Inquiry Form
CIN	Client Index Number
CIR	Claim Inquiry Response
CM/SUR	Compliance Management/Surveillance and Utilization Review
COHS	County Organized Health Systems
CNA	Consultant Not Available
CSC	Customer Service Center
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
EVC	Eligibility Verification Confirmation Number
FFS	Medi-Cal Fee-For-Service
DHCS	Department of Health Care Services
DCN	Document Control Number
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Services
GMC	Geographic Managed Care
HLD Index	Handicapping Labio-Lingual Deviation Index California Modification Score Sheet
HMO	Health Maintenance Organization

IE	Ineligible
IVR	Interactive Voice Response System
MCP	Managed Care Plan
MF-O	Maxillofacial-Orthodontic Services
MOC	Manual of Criteria
NOA	Notice of Authorization
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OO	No Aid Code
PAVE	Provider Application and Validation for Enrollment Portal
PED	Provider Enrollment Division
PHP	Prepaid Health Plan
PIN	Personal Identification Number
POS	Point of Service
RR	Responsible Relative
RTD	Resubmission Turnaround Document
SAR	Service Authorization Request
SCG	Service Code Groupings
SMA	Schedule of Maximum Allowances
SOC	Share of Cost
TAR	Treatment Authorization Request
TIN	Tax Identification Number
UCR	Usual, Customary and Reasonable
W&I	Welfare and Institutions Code

Adjudication Reason Codes

In adjudicating claim and TAR forms, it is sometimes necessary to clarify the criteria for dental services under Medi-Cal Dental. These processing policies are intended to supplement the criteria. The Adjudication Reason Code is entered during processing to explain unusual action taken (if any) for each claim service line. These codes will be found on Explanations of Benefits (EOBs) and Notices of Authorization (NOAs).

ARC #	Adjudication Reason Code Description
	Orthodontic Services
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200A	Adjustments of banding and/or appliances are allowable once per quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
	Maxillofacial Services
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12 month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.

ARC #	Adjudication Reason Code Description
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.

ARC #	Adjudication Reason Code Description
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon’s provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: “CCS approved” stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.

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 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.

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 Eligibility

CCS-only and CCS/Medi-Cal members are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the Point of Service (POS) Network. For additional information about eligibility, refer to the Medi-Cal Dental Provider Handbook, Section 9: Special Programs.

A member's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treatment. When the member changes from the CCS/Medi-Cal program to the CCS-only program, providers must obtain a Service Authorization Request (SAR) from CCS, which is explained later in this section.

Processing Guidelines

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 the Medi-Cal Dental Program. 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 the Medi-Cal Dental Program.

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 following is an explanation of the CCS Service Authorization Request (SAR) process, the System-Generated SAR process, Service Code Groupings (SCG), and a list of related CDT 22 procedure codes.

Service Authorization Request (SAR) Process

CCS-only eligible members will require a Service Authorization Request (SAR) from the CCS program for orthodontic treatment. A SAR must be obtained from CCS before diagnostic and treatment services are provided. CCS does not pay for services rendered prior to the date of referral.

The CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (CDHS 4516) may be used to refer a member to the CCS program, and/or may be used by the dental office to request services for a member's CCS-eligible condition. (In the case of an emergency, the orthodontist may provide treatment, but must submit the SAR to the CCS office by the next business day). This form may be downloaded from The California Department of Health Services website at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4516.pdf .

Instructions on how to complete this form are located on the back of the form. Orthodontic providers should use only the CDT- 22 procedure codes found in the Medi-Cal Dental Provider Handbook instead of medical procedure codes. The SAR may be faxed or mailed to the appropriate CCS county/regional office (see example of the CCS Dental and Orthodontic Client SAR form at the end of this section).

System-Generated SAR Process

If the requested services are medically necessary, the CCS program will determine the 'scope of benefits' and return a system-generated SAR to the dental office. The system-generated SAR is sent by mail only and will not be faxed (see example of the system-generated SAR form at the end of this section).

The SAR will list the Service Code Groupings number and/or individual CDT-22 procedure codes. The SAR will provide the CCS authorization begin date and end date. SAR's for orthodontic treatment are usually issued for up to one year. The SAR is not transferable between providers. Each provider who wishes to treat a CCS-only member must submit their own Dental and Orthodontic Client SAR form and receive a system-generated SAR from CCS.

After receiving the system-generated SAR, providers are to refer to the Medi-Cal Dental Provider Handbook to determine if a TAR is required. Orthodontists must follow the Medi-Cal Dental policies and procedures to provide orthodontic services that are within the CCS authorized scope of benefits.

It is not necessary for the dental office to attach a copy of the CCS SAR to Medi-Cal Dental claims and TARs. CCS will electronically transmit the SAR to Medi-Cal Dental, which must be received before services can be paid or authorized.

When providers receive the system-generated SAR from CCS, they may conduct the orthodontic examination (which includes completion of the HLD Index Score Sheet) following the guidelines described in this packet.

If CCS-only members require services beyond the scope of the Medi-Cal Dental program, they may qualify for "Non Medi-Cal Benefits." Providers will submit documentation directly to CCS and will continue to use the CMS-1500 claim forms for these services.

Service Code Groupings (SCG)

An approved SAR will list the SCGs and/or individual procedure codes based on the provider's requested treatment plan and the member's medical condition. There are 18 SCGs which are grouped by treatment plans and procedure codes to assist the CCS program in determining services based on the member's CCS-eligible medical condition. SCGs related to orthodontic services are listed in this section. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from CCS. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Medi-Cal Dental Provider Handbook, Section 5: Manual of Criteria.

A CCS SAR with an SCG or individual procedure code is only an authorization for the 'scope of benefits.' All Medi-Cal Dental policies, procedures, and requirements will apply to services authorized by a CCS SAR. Providers must refer to the Medi-Cal Dental Provider Handbook prior to treating a CCS-only member.

Following is the SCGs list for orthodontic services. For a complete listing of all SCGs, refer to the Medi-Cal Dental Provider Handbook Section 9 (Special Programs).

CCS-only Service Code Groupings for Orthodontic Services

SCG 02 – **Orthodontic Services for Medically Handicapping Malocclusion**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 03 – **Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 04 – **Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 05 – **Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 06 – **Primary Dentition for Facial Growth Management Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

SCG 07 – **Mixed Dentition for Facial Growth Management Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

SCG 08 – **Permanent Dentition for Facial Growth Management Orthodontic Services**
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

CCS-only Procedure Code Listing for Orthodontic Services

Medi-Cal Dental criteria applies to all procedure codes, as do all Medi-Cal Dental policies, procedures, and requirements. CCS-only member's have additional benefits and modifications based on frequency and age limitations. Providers may request SAR authorizations for the SCGs listed, or for additional procedure codes not listed in this table, refer to the Medi-Cal Dental Provider Handbook.

Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D0210	Intraoral, Complete Series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic Film	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	Cephalometric Film	Allowed for final records for orthodontic treatment
D0350	Oral/facial Images (including intra & extraoral images)	A benefit for final records for orthodontic treatment
D0470	Diagnostic Casts	One additional benefit for final records

For further information regarding the CCS program refer to the Provider Handbook Section 9 (Special Programs).

CCS SAR used by providers to request authorization from CCS Example

State of California—Health and Human Services Agency

Department of Health Care Services
California Children's Services (CCS)

CCS DENTAL AND ORTHODONTIC CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request
2. Provider name
3. Provider number
4. Address (number, street) | City | State | ZIP code
5. Contact person
6. Contact telephone number ( )
7. Contact fax number ( )
8. Contact email address

Client Information

9. Client name—last | first | middle
10. Gender ☐ Male ☐ Female
11. Date of birth (mm/dd/yy)
12. CCS case number
13. Home phone number ( )
14. Cell phone number ( )
15. Work phone number ( )
16. Email address
17. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code
18. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code
19. County of residence
20. Language spoken
21. Name of parent/legal guardian
22. Mother's first and last name
23. Primary care physician (if known)
24. Primary care physician telephone number ( )

Insurance Information

25. a. Enrolled in Medi-Cal? ☐ Yes ☐ No If yes, send TAR directly to Denti-Cal; no CCS SAR should be submitted
25. b. If no, enter Client Index Number (CIN)
26. Enrolled in commercial dental insurance plan? ☐ Yes ☐ No
If yes, name of plan

Requested Services

27. Service Authorization Request for *(check all that apply)*
☐ a. CCS established client Diagnosis/ICD-10:_____ ☐ b. CCS orthodontics ☐ c. Service Code Group (SCG)

28. Procedure Code/SCG	29. Tooth Number/ Letter/Arch	30. Description of Service (Including X-rays, prophylaxis, etc.)	31. Quantity	32. Fee
			33. Total fee:	

34. Is this a CCS supplemental services request ☐ Yes ☐ No
35. Other documentation attached ☐ Yes ☐ No
36. Comments

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not being processed.

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 page two of this form.

37. Signature of dental provider or authorized designee
38. Date

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CCS SAR used by providers to request authorization from CCS (2 of 2 pages)

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter either your Denti-Cal billing number (no group numbers) or NPI.
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.
8. Contact person's email address Enter the email address of the contact person.

Client Information

9. Client name: Enter the client's name—last, first, and middle.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS case number: Enter the client's CCS number. If not known, leave blank.
13. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
14. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
15. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
16. Email address: Enter the email address for the client or client's legal guardian.
17. Residence address: Enter the address of the client. Do not use a P.O. Box number.
18. Mailing address: Enter the mailing address if it is different than number 17.
19. County of residence: Enter residential county of the client.
20. Language spoken: Enter the client's language spoken.
21. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
22. Mother's first and last name: Enter the client's mother's name.
23. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
24. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

25. a. Is child enrolled in Medi-Cal? Mark the appropriate box. If answer is yes, do not send SAR to CCS, send TAR directly to Denti-Cal.
    b. If the answer is no, enter the Client Index Number (CIN).
26. Is child enrolled in a commercial dental insurance plan? Mark the appropriate box. If the answer is yes, enter the name of the commercial dental insurance plan.

Requested Services

27. a. CCS established client: Check if requesting approval for an established CCS client. Write diagnosis or ICD-10 code.
    b. CCS Orthodontics: Check if requesting approval for orthodontic services. (Check a. and b. if both apply.)
    c. Service Code Group (SCG): Check if covered by CCS SCG and enter SCG number in column 25. (Check a., b., & c. if all apply.) SCGs can be found in the Denti-Cal Provider Handbook at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Go to Section 9 Special Programs and scroll to SCGs.
28. Procedure Codes/Service Code Groups: Use the appropriate Denti-Cal American Dental Association's (ADA) Current Dental Terminology (CDT) codes for each service, and/or use CCS Service Code Group(s) (SCG). The CDT codes are found in Section 5 of the Denti-Cal Provider Handbook: http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf and the SCG are found in Section 9 of the Handbook, at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Do not duplicate individual procedure codes included in a SCG. Note: Denti-Cal does not use the latest CDT codes.
29. Tooth number or letter; arch; quadrant: Enter the universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use applicable arch codes U (upper), L (lower). Use quadrant codes UR (upper right), UL (upper left), LR (lower right), and LL (lower left).
30. Description of service: Furnish a brief description for each service. Standard abbreviations are acceptable.
31. Quantity: For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (procedure D0230); number of additional units for general anesthesia (procedure D9221).
32. Fee: Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.
33. Enter total fee to be charged.
34. Check yes or no box if this is a CCS Supplemental Services Request.
35. Check yes or no box if there is other documentation attached.
36. Comments. Enter any additional comments.

Signature

37. Signature of dental provider: Form must be signed by the dentist, orthodontist, or authorized representative.
38. Date: Enter the date the request is signed.

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System-generated SAR Issued by CCS to the Dental Office Example

CONFIDENTIAL

SAR#

XXXXXXXX COUNTY CCS OR REGIONAL OFFICE
CALIFORNIA CHILDREN'S SERVICES (CCS)
ADDRESS 1
ADDRESS 2
CITY, ST ZIP
TELEPHONE:

AUTHORIZATION FOR SERVICES

Authorization is for services and effective dates indicated below, in accordance with CCS program policies and fee schedule. Authorization for additional services not listed below must be requested in advance. By providing these authorized services, I agree to accept payment from the CCS program as payment in full. If you have a Service Code Grouping (SCG) authorization, please check your Denti-Cal manual for services included in the SCG.

Authorized Provider:	Facility Name Line 1 Line 2 Line 3 City, St Zip	Provider No: 99999999999 Telephone: (999)999-9999

CCS CLIENT INFORMATION

Client Name:	Name, Client	Client Index Number:	99999999A9
Parent/Guardian:	Mr. and Mrs. Etc.	Medi-Cal Number #:	99999999999999
Address:	Line 1	CCS Case Number:	9999999
	Line 2	Date of Birth:	9/99/9999
	City, State Zip	Telephone:	(999) 999-9999

AUTHORIZATION INFORMATION

Effective Dates: 11/03/2018 through 11/30/2019

CCS AUTHORIZED SERVICES

<SERVICE CODE> or <SCG>	< SERVICE CODE DESCRIPTION>	<QUANTITY>

SPECIAL INSTRUCTIONS

<SPECIAL INSTRUCTIONS>

Please refer to the Denti-Cal manual for billing instructions. Thank you for your continued participation in the California Children's Services program.

Issued By: NAME, USER (XXXXX COUNTY OR REGIONAL OFFICE) Date Authorized: 12/01/2016

SAR#:

Dental SAR rules

1) Quantity should not display for service code groupings
2) The Authorized Provider name and address fields should fit into a standard window envelope
3) The Parent/Guardian name and address default from the primary addressee from patient registration