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Provider Bulletin

OCTOBER 2021
Volume 37, Number 21

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TRAINING SEMINARS

To reserve a spot online or view a complete list of training seminars, go to the Provider Training Seminar Schedule.

Please note: Due to the COVID-19 pandemic, all seminars will be held as webinars.

PROVIDER ENROLLMENT ASSISTANCE LINE

Speak with an Enrollment Specialist. Go here for more information.

Available every Wednesday
8am - 4pm

PROVIDER EMAIL LIST SIGN-UP

Registration is quick and easy! Join the provider email distribution list and get the latest Medi-Cal Dental updates straight to your Inbox.

Coming Soon: Health Plan of San Mateo (HPSM)

Dental Integration Program

Effective January 1, 2022, the San Mateo County Organized Health System, Health Plan of San Mateo (HPSM), in collaboration with the Department of Health Care Services, will integrate dental services into the managed care plan's covered benefits. Medi-Cal dental Fee-For-Service (FFS) providers who wish to continue serving Medi-Cal members in San Mateo County must join HPSM's dental provider network.

Why will Medi-Cal dental benefits be delivered through HPSM?

Senate Bill (SB) 849 (Ch. 47, Statutes of 2018) added Section 14184.90 to the Welfare and Institutions (W&I) Code authorizing DHCS to establish a dental integration program in San Mateo County as a component of the Medi-Cal 2020 demonstration project.

What is this dental integration program designed to do?

The program is designed to test the impact to oral care access, quality, and utilization through the delivery of dental care services under HPSM.

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How will I know if this change affects me?

If you are a provider located in San Mateo County this change affects you. In May 2021, HPSM contacted all Medi-Cal dental FFS providers in San Mateo County by phone, mail, or in-person about this change. Medi-Cal Dental also sent these providers notifications regarding HPSM informational webinars held on May 20 and 25, 2021.

How do I become part of HPSM's dental provider network?

For information about how to join HPSM's provider network, call (650) 616-5046 or email dental@hpsm.org. Providers are encouraged to contract with HPSM as soon as possible prior to January 1, 2022, to ensure continuity of care for Medi-Cal patients in San Mateo County.

Can I continue seeing my Medi-Cal patients if I choose NOT to join HPSM's provider network?

If you choose not to contract with HPSM and your Medi-Cal patients wish to continue seeing you, they may submit a continuity of care request to HPSM. If you agree to work with HPSM, your patients may continue seeing you for up to 12 months. After the 12-month period, unless you join HPSM's provider network, your Medi-Cal patients will transition to a dental provider within the HPSM provider network. Your Medi-Cal patients may contact HPSM Member Services at 1-800-750-4776 (toll-free) or 650-616-2133, Monday through Friday, 8:00 a.m. to 6:00 p.m. for more information.

How will my impacted Medi-Cal patients be notified of this change?

HPSM will mail notices to Medi-Cal members enrolled in HPSM to inform them of this change 90 days in advance, followed by 60- and 30-day notices. In addition to the 60 and 30 day notices, HPSM is required to conduct additional outreach to members which may include newsletters, pamphlets, or other mailers.

For questions about the HPSM transition, please contact HPSM at (650) 616-5046 or dental@hpsm.org. Providers can also visit the HPSM website for more information.

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Take the 2021 Provider Network Capacity Survey

Medi-Cal Dental is pleased to announce that dental providers enrolled in Medi-Cal have an opportunity to take the 2021 Provider Network Capacity Survey online **now through October 29, 2021**.

The goal of this survey is to:

- Identify potential access-to-care barriers within the Medi-Cal Dental Program
- Understand how providers were impacted by the recent increase in the Medi-Cal patient population and how they have managed it

Providers can also find the survey on the Medi-Cal Dental website and *Smile, California* website. **Some providers will additionally receive a copy of the survey in the mail. Please only take the survey once.**

Oral Health Literacy Toolkit

Medi-Cal dental providers are encouraged to check out the Oral Health Literacy Toolkit. The toolkit offers:

- An overview of what oral health literacy is and why it matters
- Practical tools and roadmaps for improving the health literacy of dental practices

Currently, the toolkit consists of the following:

» Oral Health Literacy in Practice

» Practice Assessment Checklist

» What is Teach-Back?

» Going to the Dentist Patient Brochure

» Oral Health Literacy Action Plan

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This toolkit was developed and based on research conducted by Health Research for Action, a research center of UC Berkeley's School of Public Health, in collaboration with the California Department of Public Health Office of Oral Health. Providers can visit the dedicated Oral Health Literacy Toolkit for more information.

Tips for Successful Billing

Below is information about common Medi-Cal dental billing issues along with helpful tips and suggestions for preventing denials from occurring. Please refer to Section 7 – Codes in the Provider Handbook, for a complete list of Adjudication Reason Codes (ARCs).

Top Denials

- **ARC 004** - *Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.*
    - All Medi-Cal patients three years of age and older require a Comprehensive Oral Evaluation (procedure code D0150) before the program can allow a Periodic Oral Evaluation (procedure code D0120). Providers may submit a Claim Inquiry Form (CIF) to correct the procedure code for payment.

- **ARC 340/341**
    - **ARC 340** - *This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a CIF. The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six months from the date of the EOB on the original claim.*
        - Duplicate claims are not accepted. Providers may make corrections on the original claim by submitting a CIF.
    - **ARC 341** - *This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a CIF. This denied, duplicate procedure does not extend the time limit to request*

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re-adjudication; you have up to six months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)

- Duplicate claims are not accepted. Providers may make corrections on the original claim by submitting a CIF.

X **ARC 326** - *Procedures being denied on this document due to invalid response to the Resubmission Turnaround Document (RTD) or, if applicable, failure to provide radiographs/attachments for this Electronic Data Interchange (EDI) document.*

- Providers should ensure they are able to access and interpret their electronic RTD reports. If you signed up for electronic RTD reports, you will not receive paper RTDs. Often, this type of denial occurs when a required radiograph or attachment is missing from the electronic document. Please make sure to check all procedure codes for attachment requirements before submitting.

X **ARC 081** - *Periodontal procedures cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs and/or charting.*

- Radiographs must show evidence of bone loss, clinical attachment loss, or subgingival calculus for approval.

X **ARC 267** - *Documentation not submitted.*

- For current submission and documentation requirements, please refer to the draft Current Dental Terminology (CDT) 2021 Manual of Criteria (MOC) for the procedure requested.

X **ARC 320A** - *Rendering or billing provider is not enrolled as a certified orthodontist.*

- The program only allows procedure code D0140 limited exam payable to certified orthodontists. If you are billing for an emergency office visit, you may use procedure code D9430.

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- **ARC 031/031A**
  - **ARC 031** - *Procedure is payable only when submitted.*
    - Unlike radiographs, photographs must be submitted for review on the same claim as the procedure they support to be payable.
  - **ARC 031A** - *Photographs are a benefit only when appropriate and necessary to document associated treatment.*

- **ARC 337** - *The procedure is not a benefit for the age of the member.*
  - For age limitations on specific procedures, please refer to the draft CDT-21 MOC.

- **ARC 128** - *Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.*
  - Providers should submit their request for a post and core along with the crown request to avoid payment delay.

- **ARC 113/113C**
  - **ARC 113** - *Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.*
    - The tooth may not be missing the required amount of tooth structure to qualify for a crown. For crown requirements, please refer to the draft CDT-21 MOC.
  - **ARC 113C** - *Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis. Please reevaluate for alternate treatment.*
    - Providers may want to consider a prefabricated crown or other benefit procedure for the member.

- **ARC 048** - *Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.*
  - Payment is not made for elective extractions on asymptomatic teeth.

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Clinical Reasons for Denials

- Non-diagnostic radiographs
- Missing or incomplete submission of radiographs
- Radiographs/photographs fail to demonstrate medical necessity for restorative procedures
- Poor prognosis for treatment:
    - Tooth/teeth/arch show severe bone loss
    - Gross destruction rendering the tooth/teeth/arch unrestorable

Clerical Reasons for Denials

- Other coverage claims for payment must have an EOB/RA attached showing action taken from primary carrier. **Medi-Cal is always the secondary carrier**.
- Failure to submit treating provider/NPI numbers.
- Using the Billing NPI (type 2) in Box 20 on and the rendering NPI (type 1) in Box 33 on the claim form. Refer to Provider Handbook Section 6 – Forms, for detailed instructions.
    - **Please note**: Providers who submit through EDI should especially watch for this issue. To ensure the correct boxes have been selected, EDI submitters are encouraged to print a test claim prior to submission.

Helpful Hints to Avoid Denials

Avoid delays in payment and the denial of Claims and Treatment Authorization Requests (TARs) with the following tips.

- Members 21 years and older
    - **Authorized procedures on a NOA**
        - Medi-Cal Dental authorized treatment on an NOA may be allowed even though the member's 21st birthday occurs before the expiration date on the NOA. Procedures requiring prior authorization will be payable as long as the member is eligible at the time services are rendered.

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    - » Orthodontic coverage is a benefit to age 21 for qualifying members. Authorized Ortho treatment may be rendered on an eligible member through the month of their 21st birthday.

- When submitting for payment, rubber stamps or "signature on file" cannot be accepted on Medi-Cal Dental forms (i.e. claims/TARs/NOAs/RTDs/CIFs). A **signature in blue or black ink** is required from the provider or authorized staff member.
- Use the existing NOA for a re-evaluation of a denied procedure by marking the re-evaluation box on the upper right corner and check the attachment box. **Do not** submit a CIF when requesting re-evaluation of a denied procedure on a TAR.
    - If you are billing electronically, you may opt to submit a new electronic TAR in lieu of the NOA for reevaluation.
- Bitewing radiographs are considered arch films and are considered current for a period of 36 months for purposes of establishing arch integrity.
- Anterior periapical radiographs and bitewings are enough to establish arch integrity of the upper/lower arches.

For current submission and criteria requirements, please refer to the draft CDT-21 MOC and draft CDT-21 Schedule of Maximum Allowances (SMA) for dates of services on or after October 1, 2021.

Outdated Form: Justification of Need for Prosthesis

Effective January 1, 2022, providers must use Justification of Need for Prosthesis (DC054) forms with a **revision date of Rev 09/18** when submitting to Medi-Cal Dental. To confirm the version, check the revision date at the bottom of the form.

Outdated DC054 forms received after January 1, 2022 will be denied with **Adjudication Reason Code (ARC) 155** - *Procedure requires a properly completed prosthetic DC054 form*.

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Order New Forms

Please recycle any old forms and reorder new ones. To order, please complete and fax the Forms Reorder Request to the number on the form.

How to Complete the DC054 Form

Refer to Medi-Cal Dental Provider Handbook Section 6 – Forms, for detailed instructions.

Save Time and Submit Electronically

For Electronic Data Interchange (EDI) enrollment information, please contact:

- **EDI Support** at (916) 853-7373 or Medi-CalDentalEDI@delta.org
- **Telephone Service Center** at (800) 423-0507

NOTE: Safety Net Clinics (Federally Qualified Health Centers, Rural Health Clinics, and Tribal 638 Clinics) are not subject to prior authorization. However, documentation should be consistent with the standards set forth in the Manual of Criteria (MOC) for Medi-Cal Authorization (Dental Services) and all state laws. A current DC054 form is required for screening and processing prosthetic cases and must be retained as part of patient records.

For current submission and criteria requirements, please refer to the draft Current Dental Terminology (CDT) 2021 MOC and draft CDT-21 Schedule of Maximum Allowances (SMA) for dates of services on or after October 1, 2021.