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MEDI-CAL HAS DENTAL COVERED

Provider Bulletin

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THIS ISSUE

SIGN UP FOR OUR EMAIL LIST

Learn the latest Medi-Cal Dental news and information by signing up for our Medi-Cal Dental Fee-For-Service Provider email distribution list here.

TRAINING SEMINARS

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

New Signature Standards For All Medi-Cal Dental Forms

Effective immediately, only electronic signature (secure digital) or wet signature (pen-to-paper) will be accepted on all Medi-Cal Dental forms and documentation.

This strict signature requirement will protect both providers and members by ensuring all claims, authorizations, and records are legally valid, secure, and fully compliant with Medi-Cal standards.

What's Changing

Going forward, providers must use:

- **Electronic signatures**: These are generated through an approved and secure electronic system.
- **Wet signatures**: These are traditional pen-to-paper signatures on physical documents.

Effective immediately, the following **will not** be accepted and may result in processing delays:

- Stamped signatures or stamped provider names
- Typed or printed names
- Handwritten names that are not a signature

Adhering to these standards helps ensure your forms are processed without delay, improves audit outcomes, and reduces risk of fraud or disputed records.

Continued on pg 2

If you have questions or need additional support, please contact the Medi-Cal Dental Telephone Service Center (TSC) toll-free at (800) 423-0507. Medi-Cal Dental representatives are available to answer phone calls between 8:00 a.m. to 5:00 p.m., Monday through Friday to assist you. For general program information, the Medi-Cal Dental Interactive Voice Response System (IVR) is available 24 hours a day, seven days a week, using the automated system. For assistance with claims submission and documentation, please visit the California Outreach Map to contact your regional representative.

Know the Difference: Appropriate Documentation, Pattern Documentation, and Templates

Medi-Cal Dental providers are required to maintain accurate clinical records that reflect the actual services rendered, the medical necessity for those services, and the unique conditions of each Medi-Cal member. Misuse of templates or reliance on repetitive, non-specific language (pattern documentation) can lead to denied claims, audit findings, or potential fraud investigations. More detailed information is available in Section 4: Treating Members section of the Provider Handbook.

Below are some best practices to ensure compliance with Medi-Cal Dental requirements and support the integrity of patient care documentation:

1. **Document services accurately**. Include exactly what was done, why it was medically necessary, and how it was tailored to the patient's unique condition. Clinical notes are to be specific to the patient's encounter, this includes findings, diagnosis, treatment provided, and rationale.

2. **Avoid repetitive, generic, or copy-paste notes**. Each patient encounter should be documented in a way that reflects individualized care. Repetitive language used across multiple patient records may not reflect the actual clinical situation and can raise red flags during audits.

3. **Use templates wisely**. Templates can help with efficiency but remember that they must be customized for each patient. While pre-filled or standardized forms used to streamline documentation can be helpful, they must be customized for each patient and not used as a substitute for individualized clinical notes.

Continued on pg 3

Learn More About Patient Care Documentation

You can find more information about documentation standards in Section 4: Treating Members as well as Section 8: Fraud, Abuse, and Quality of Care of the Medi-Cal Dental Provider Handbook.

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Reminder: Accurate CDT Codes Are Required On All Claims

Accuracy in Current Dental Terminology (CDT) coding on claim forms ensures that claims are processed correctly, timely, and services are fully compliant with Medi-Cal Dental requirements.

Important

Providers must always use the CDT code that most accurately describes the dental service performed. The full set of covered CDT procedure codes and descriptions is available in the Provider Handbook; Section 5 - Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA).

Example of Inaccurate CDT Coding

A claims is submited with CDT **D2930 (Prefabricated Stainless-Steel Crown – Primary Tooth)** instead of **D2929 (Prefabricated Porcelain/Ceramic Crown – Primary Tooth)** when using a prefabricated zirconia crown.

A substitution such as this is considered inaccurate for coding because the CDT code billed must always reflect the material and procedure documented. Submitting a claim under an incorrect code, even with good intentions to help a patient reduce costs or out-of-pocket expenses, constitutes the misrepresentation of services and may be subject to administrative action or penalties under State and Federal laws.

Continued on pg 4

Program Compliance and Legal Obligations

All Medi-Cal dental claims must accurately represent the services performed. Knowingly submitting inaccurate or misrepresented claims can violate the **California False Claims Act** (Government Code Sections 12650 – 12656). Violations may result in audits, civil penalties, damages, and exclusion from Medi-Cal Dental and other public health care programs.

Providers must maintain complete legible and contemporaneous documentation supporting every claim submitted, including treatment notes, radiographs, and materials used in accordance with Medi-Cal documentation standards. For more information, see Section 4: Treating Members of the Provider Handbook.

CDT Code Best Practices

Providers are encouraged to use the following best practices to ensure accurate CDT codes are billed:

- Review the Provider Handbook.
- Educate staff on accurate coding, billing standards, and documentation practices.
- Retain proper documentation for every claim, including all supporting materials.
- Avoid substituting CDT codes to accommodate insurance coverage limits.
- Correct and resubmit claims promptly if errors are discovered.

Please note: "Code for what you do" is the fundamental rule to apply in all coding situations. It demonstrates the dentist's adherence to the American Dental Association's Principle of Ethics and Code of Professional Conduct. If there is no applicable code, document the service using an unspecified, by report ("999") code, and include a clear and appropriate narrative.

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