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# Provider Bulletin

APRIL 2026
Volume 42, Number 09

## THIS ISSUE



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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.

# Best Practices for Working with Billing Intermediaries

Many providers rely on assistance from **billing intermediaries** (also known as billing services) to facilitate claim submission and reimbursement.

While these third parties can offer administrative support, the ultimate responsibility for the accuracy of all submitted claims rests with the provider.

Here are some of the best practices to ensure your practice remains compliant with program regulations.

### Best Practices

1. **Registration:**
   Ensure your billing intermediary is properly registered with the Department of Health Care Services (DHCS). You can find registration requirements in the Medi-Cal Dental Provider and Billing Intermediary Application.
2. **Maintain Signatory Control:**
   All forms (Claims, TARs, NOAs) require a live signature from the provider or authorized staff member. Rubber stamps or "signature on file" from an intermediary are not permitted. For more information, please visit Provider Bulletin Volume 41_Number 37.
3. **Regular Reconciliation:**
   Compare your internal clinical records with the Explanation of Benefits (EOB) to ensure the services billed by your intermediary match the services that were rendered.

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4. **Update Contact Information:**
   Promptly report changes to your business or "pay-to" address via the PAVE Provider Portal to prevent deactivation of your billing NPI.

**Helpful Resources**

Provider Handbook: Section 3 - Enrollment Requirements of the Medi-Cal Dental Provider Handbook provides details on the NPI requirements and the necessity of notifying DHCS of any changes to billing information within 35 days.

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.

# How to Avoid Common Claim and Treatment Authorization Request Errors

Medi-Cal Dental is dedicated to ensuring that providers receive timely reimbursement on their claim submissions and authorization decisions for their Treatment Authorization Requests (TARs). This article provides best practices to resolve common errors for both claims and TARs, and helps providers experience faster processing times, improve cash flow, and reduce administrative burden associated with appeals and resubmissions.

**Common Errors and Best Practices**

1. **Missing or Inadequate Radiographs**

   - **Common Error:** Images that are too dark, too light, or do not show the entire tooth including the apex.
   - **Best practice:** Ensure all radiographs are mounted correctly and clearly labeled with the patient's name, date-of-service, and tooth number or orientation. Per the Manual of Criteria (MOC), radiographs must be of diagnostic quality. If a digital image is printed, it must be on high-quality photographic paper.

2. **Incorrect Procedure Codes and Tooth Numbering**

   - **Common Error:** Using outdated Current Dental Terminology (CDT) codes or mismatched tooth numbers and surfaces.

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- **Best practice:** Always refer to the current Schedule of Maximum Allowances (SMA) to verify that procedure codes are active. Cross-reference the tooth number with the age of the patient to ensure the code is appropriate for primary versus permanent dentition.

3. **Incomplete Clinical Documentation and Narratives**

   - **Common Error:** Providing a generic narrative that does not explain the specific clinical necessity for a procedure.
   - **Best practice:** Required narratives should be specific to that patient and the specific tooth or area. Narratives should not contain generalized statements but be specific to the member's oral health situation and include tooth-specific narrative. For detailed requirements by procedure type, see the Manual of Criteria (MOC).

4. **Recipient Eligibility and Name Mismatches**

   - **Common Error:** Submitting claims with a name or Benefits Identification Card (BIC) number that does not match Medi-Cal's records.
   - **Best practice:** Verify eligibility on the date-of-service using the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 or using the Medi-Cal Provider Portal. Ensure the name on the claim matches the name returned by the eligibility system exactly.

5. **Missing Information/Documents**

   - **Common Error:** Missing information or documents with the claims or TAR submission.
   - **Best practice:** Office staff should implement a pre-submission checklist based on Section 2 - Program Overview:
     - ➢ Verify that the provider's National Provider Identifier (NPI) and address match the information on file with Medi-Cal Dental.
     - ➢ Confirm that all required attachments (x-rays, periodontal charts, narratives) are included with the initial submission.
     - ➢ Check that the "Date of Service" is accurate and matches the clinical notes.

**Additional Resources**

For more information on this topic, consult the Claim and TAR Submission Frequently Asked

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Questions (FAQs) for troubleshooting specific rejection codes and common billing scenarios or visit the Provider Training webpage for upcoming seminars and on-demand training.

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# Member Eligibility Verification

Verifying members' Medi-Cal eligibility is a critical first step before any dental service is rendered. To reduce hold times through calling the Telephone Service Center, providers should use the **Automated Eligibility Verification System (AEVS)** or the **Medi-Cal Dental Website (Provider Portal)** to verify members' Medi-Cal eligibility.

**Eligibility Verification Methods**

Per the Medi-Cal Dental Provider Handbook, Section 4 - Treating Members, providers must use one of the following three official methods to verify a member's eligibility:

1. **Automated Eligibility Verification System (AEVS)**
   The AEVS is available 24 hours a day, seven days a week. Providers can access AEVS by calling **(800) 456-2387**. You will need your Provider National Provider Identifier (NPI) and the member's Benefits Identification Card (BIC) ID number or Social Security Number.
2. **Medi-Cal Dental Website (Provider Portal)**
   Providers may also verify eligibility directly through the Medi-Cal Provider Portal. Once logged in, providers can perform a real-time eligibility search.

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.

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# Updates to the Online Care Coordination Form

Medi-Cal Dental would like to highlight updates to the Online Care Coordination Form, which can be filled out by providers, members, and any member representatives to request for assistance to help members locate a specialty provider (endodontist, orthodontist, etc.), schedule an appointment, coordinate translation support, or obtain transportation. These updates ensure Medi-Cal Dental Care Coordinators have as much information as possible to begin assisting members right away.

**Key Updates**

- New required fields include: member's address, member's phone number, and member's spoken language.
- Revised questions with more categories to accurately capture dental needs (such as General Anesthesia) including blank space for additional details.
- New option to identify the requestor's relationship to member (such as Regional Center Representative).
- New option for requestor to obtain Case Summary, if permissible per the Health Insurance Portability and Accountability Act.

Completing the updated Care Coordination Form ensures Medi-Cal Dental receives information needed to efficiently assist members and improve their Care Coordination experience. Complete submissions help the Care Coordinators reach out to members quickly and connect them with appropriate services.

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# Member Transportation is Available

Medi-Cal Dental recognizes that transportation is one of the most significant barriers to successfully accessing care for Medi-Cal members.

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To help avoid members missing their appointments, this article provides information on how to assist members in accessing **Non-Medical Transportation (NMT)** and **Non-Emergency Medical Transportation (NEMT)**.

### Non-Medical Transportation (NMT)

NMT is available to members who can travel by standard vehicle (car, bus, train, or taxi) but do not have a reliable way to get to their dental appointment or to pick up prescriptions.

- **For members enrolled in a Medi-Cal Dental Managed Care (DMC) plan**, the member or dental office staff can contact the plan's Member Services department to coordinate transit. For more contacts to DMC plans, please visit Dental Managed Care (DMC) Member Contact Information.
- **For members in Fee-For-Service**, providers can complete the NMT/NEMT Scheduling Form on the Transportation Services webpage and request for transportation assistance for the member. For more information please visit Section 4 of the Provider Handbook.

Dental office staff should verify member's transportation status during the appointment reminder call. If a member identifies a transit barrier, refer them to the Transportation Services webpage for additional assistance.

### Non-Emergency Medical Transportation (NEMT)

NEMT is a specialized service for members whose medical, physical, or mental condition prevents them from using public or private transportation. This service is authorized when the member's condition meets the criteria outlined in the Medi-Cal Dental Provider Handbook, Section 4 - Treating Members.

NEMT includes:

- **Wheelchair Vans:** For members who can sit upright but require a lift-equipped vehicle.
- **Litter Vans:** For members who require a stretcher during transport.
- **Ambulances:** For members requiring medical supervision or specialized equipment.

Unlike NMT, NEMT requires a **Prescription or Physician Certification Statement (PCS)**. As a Medi-Cal Dental provider, you have the authority to determine the medical necessity for NEMT. For detailed clinical criteria and authorization requirements, please refer to Section 4 - Treating Members and the Manual of Criteria (MOC) regarding specialized patient accommodations.

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You must document the specific physical or medical limitation that necessitates NEMT in the patient's record. Visit the Transportation Services page for more information and access to the **NMT/NEMT Scheduling Form**.

**Best Practices for Providers**

- **Early Coordination:** Encourage members to request transportation as soon as the appointment is scheduled. Most transit providers require notice of at least **5 business days**.
- **Plan for Recurring Appointments:** For treatment plans requiring multiple visits, providers can help set up "standing orders" for transportation to ensure the patient arrives for every phase of treatment.

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# Discontinuation of Proposition 56 Supplemental Payments

Please be aware that with the 2025-2026 California State Budget (Senate Bill 101) decisions, Proposition 56 (Prop 56) supplemental incentive payments to Medi-Cal Dental providers will discontinue effective July 1, 2026. Claims submitted for date of service on or after July 1, 2026, will be reimbursed solely at the Schedule of Maximum Allowances (SMA) amount.

**What to Expect**

- The last supplemental payments will be issued for services rendered on or before June 30, 2026.
- A one-year claims runout period begins July 1, 2026, through June 30, 2027 for submission of any outstanding claims for services.
- Effective July 1, 2026, only SMA Medi-Cal reimbursement rates will apply for affected procedure codes.
- Explanation of Benefits (EOB) statements will include notification language: "Prop 56 supplemental payments are discontinued for dates of services on or after July 1,

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2026. For more information on the discontinuation of Prop 56, go to https://dental.dhcs.ca.gov."

**Steps You Can Take Now**

- Review your current reimbursement structure and identify procedures currently receiving Prop 56 supplemental payments.
- Calculate the financial impact on your practice effective **July 1, 2026**.
- Assess your Medi-Cal Dental patient care capacity and scheduling considering the reduced reimbursement.
- Ensure that your billing staff understands the **June 30, 2026 deadline** for supplemental payment eligibility and verify that all claims are submitted before the runout period expires. The runout period is from July 1, 2026 through June 30, 2027. For additional information regarding reimbursement during the runout period, please review Claim Submission and Timeliness Overview (claim sub).

For detailed information on affected procedure codes and current Prop 56 schedules, visit the Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA).

**Failure to submit claims by the runout deadline may result in claims being denied or paid at base rates only. Ensure the accurate tracking of all service dates to maximize supplemental payment recovery before the effective date of July 1, 2026.**

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.