Section 2 - Program Overview

Section 2 - Program Overview

Provider Participation in the California Medi-Cal Dental Program

To receive payment for dental services rendered to Medi-Cal members, prospective providers must apply and be approved by Medi-Cal Dental to participate in Medi-Cal Dental, the details of which are found in "Section 3: Enrollment Requirements" of this Handbook. When a provider is enrolled in Medi-Cal Dental, Medi-Cal Dental sends the provider a letter confirming the provider's enrollment effective date. Medi-Cal Dental will not pay for services until the provider is actively enrolled in Medi-Cal Dental.

Compliance in Medi-Cal Dental

California Code of Regulations (CCR), Title 22, Section 51476, requires participants in Medi-Cal Dental to:

1. Comply with Title VI of the Civil Rights Act of 1964 (PL 88-352), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and all requirements imposed by the Department of Health and Human Services (DHHS) (45 CFR Part 80), which states that "no person in the United States shall, on the ground of race, color, religion, sex, age, disability, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives state financial assistance from the Department." Additionally, providers must comply with California Department of Corporations laws and regulations, which forbid discrimination based on marital status or sexual orientation (Rule 1300.67.10, California Code of Regulations).
2. Keep and maintain all records disclosing the type and extent of services provided to a member for a period of ten years from when the service was rendered (W & I Code, Sections 14124.1 and 14124.2).
3. Provide all pertinent records to any authorized representative of the state or federal government concerning services rendered to a member (California Code of Regulations (CCR), Title 22, Section 51476(g)).
4. Not bill or collect any form of reimbursement from members for services included in Medi-Cal Dental scope of benefits, with the exception of Share of Cost (California Code of Regulations (CCR), Title 22, Section 51002).
5. Certify:
    - the services listed on the Treatment Authorization Request (TAR)/Claim form have been provided to the member either by the provider or another person eligible under the Medi-Cal program to provide such services. Such person(s) must be designated on the treatment form.
    - the services were necessary to the health of the member.

- that he or she understands payment for services rendered will be made from federal and/or state funds and that any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.

All dental service claims billed by a Safety Net Clinic (SNC) and reimbursed by Medi-Cal that are rendered pursuant to a contract between the clinic and a private practice dental provider must adhere to the Medi-Cal Dental Handbook, and the applicable legal, enrollment, documentation, and treatment plan requirements.

Failure to comply with Medi-Cal Dental requirements will result in corrective actions. Please see "Section 8: Fraud, Abuse and Quality of Care" of this Handbook for more information.

Out-of-State Coverage

Out-of-state providers who wish to be reimbursed by Medi-Cal Dental for services provided to California Medi-Cal members are subject to specific regulations under California Code of Regulations (CCR), Title 22, Section 51006, Out-of-State Coverage. The regulations state:

(a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:

(1) When an emergency arises from accident, injury, or illness; or

(2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or

(3) Where the health of the individual would be endangered if he undertook travel to return to California; or

(4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or

(5) When an out-of-state treatment plan has been proposed by the member's attending physician and the proposed plan has been received, reviewed, and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State.

(6) Prior authorization is required for all out-of-state services, except:

(A) Emergency services as defined in Section 51056.

(B) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.

(b) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

More information on Out-of-State Coverage is found on the Administrative Law website here.

Written Correspondence

Most provider inquiries can be answered by using the automated system or operator-assisted options that are available through the toll-free telephone line. For protection and confidentiality, Medi-Cal Dental requires that certain inquiries and requests be made through written correspondence only. The types of inquiries and requests that must be sent to Medi-Cal Dental in writing include:

- a change or correction to a provider's name/address or other information concerning a dental practice;
- a request for a detailed printout of a provider's financial information, such as year-to-date earnings;
- a change in electronic funds transfer information, such as a different banking institution or new account number;
- a request to stop payment of or reissue a lost or stolen Medi-Cal Dental payment check.

All written inquiries and requests should contain at a minimum the following information:

- Provider name
- Medi-Cal dental billing provider number
- Date of request/inquiry
- Signature of billing provider

Written correspondence should also include any other specific information that pertains to an inquiry or request.

Direct all written correspondence to:

Medi-Cal Dental
Attn: [Name of Department]
PO Box 15609
Sacramento, CA 95852-0609

Upon receipt of written correspondence, the provider will receive acknowledgement that the request has been received by Medi-Cal Dental and is being processed.

Suspended and Ineligible Providers

Billing providers who submit claims for services provided by a rendering provider suspended from participation in Medi-Cal Dental are also subject to suspension from the Program.

Welfare and Institutions (W & I) Code, §14043.61(a) states that "a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies, or merchandise provided, directly, or indirectly, to a Medi-Cal member, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the
Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List,…or any list is published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers."

The List of Excluded Individuals/Entities compiled by the Office of Inspector General is available online here.

Enrollment Denied for Failure to Disclose Fraud or Abuse, or Failure to Remediate Deficiencies

Per Assembly Bill 1226 (Chaptered October 14, 2007, amending Sections 14043.1, 14043.26, and 14043.65 of the Welfare and Institutions Code):

A provider whose application for enrollment is denied for failure to disclose fraud or abuse, or failure to remediate deficiencies after Department of Health Care Services (DHCS) has conducted additional inspections, may not reapply for a period of three years from the date the application is denied.
Three-year debarment from the Medi-Cal program would begin on the date of the denial notice.

Applicants are allowed 60 days to resubmit their corrected application packages when DHCS returns it deficient.

General Telephone Information

Provider Toll-Free Telephone Number

For information or inquiries, providers may call the Telephone 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

Telephone Service Center Representatives are available Monday through Friday between 8:00 a.m. and 5:00 p.m., excluding holidays. Providers are advised to call between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m., when calls are at their lowest level.

Hours of operation and additional information for the Interactive Voice Response (IVR) system can be found in "Section 4: Treating Members" of this Handbook.

In order for Medi-Cal Dental to give the best possible service and assistance, please use the Telephone Service Center toll-free provider number at (800) 423-0507.

Inquiries that cannot be answered immediately will be routed to a telephone 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 Telephone Service Center toll-free member number at (800) 322-6384. The member lines are available from 8:00 a.m. to 5:00 p.m. 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) requirements of Medi-Cal Dental
4. General inquiries
5. Complaints and grievances
6. Information about denied, modified, or deferred Treatment Authorization Requests (TARs)

Contact Listings for Medi-Cal Dental

Medi-Cal Dental - Contact Medi-Cal Dental for questions related to payments of claims and/or authorizations of Treatment Authorization Requests (TARs).	
Provider Toll-Free Line	(800) 423-0507
Member Toll-Free Line	(800) 322-6384
Teletext Typewriter (TTY)	(800) 735-2922
Electronic Data Interchange (EDI) Support: Medi-CalDentalEDI@delta.org	(916) 853-7373
Conlan Help Desk	(916) 403-2007
Medi-Cal Dental Abuse Line	(800) 822-6222

Ordering Medi-Cal Dental Forms	**Provider First Level Appeal**	**Written Correspondence**
Medi-Cal Dental Forms Reorder 11155 International Dr., MS C210 Rancho Cordova, CA 95670 FAX: (877) 401-7534	Medi-Cal Dental Attn: Appeals Unit PO Box 13898 Sacramento, CA 95853-4898	Attn: [Name of Department] PO Box 15609 Sacramento, CA 95852-0609

Medi-Cal Program - Contact the Medi-Cal Program for California Children's Services (CCS)/Medi-Cal, Genetically Handicapped Persons Program (GHPP)/Medi-Cal, CCS-only, and CCS/Health Families (HF) eligibility, or Internet questions.	
Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk and Internet Help Desk	(800) 541-5555
Outside California	(916) 636-1200
Internet Eligibility Website	Click here
Attorney General's Medi-Cal Fraud Hotline	(800) 722-0432

GHPP State Office - Providers are to contact this State office for GHPP-only related questions.	
Genetically Handicapped Persons Program MS 8200 PO Box 997413 Sacramento, CA 95899	(916) 327-0470 or (800) 639-0597 FAX: (916) 327-1112

County Medical Services Program (CMSP) Questions Regarding Changes to Program: CMSP website	(916) 649-2631
Member State Hearings/To Withdraw from a State Hearing State Hearings Division PO Box 944243, MS: 19-37 Sacramento, CA 94244-2430	(855) 266-1157

Internet Access and Websites

The Medi-Cal Dental website now meets increased usability and accessibility standards and has been improved to allow for faster navigation to important topics and provider resources. A new search engine makes finding information fast and easy.

Both the Medi-Cal Dental and the Medi-Cal website are available 24 hours/day, 7 days/week. The latest versions of free browsers and other tools, such as Adobe Acrobat, may be accessed through the websites toolbox link. Both websites provide links to other sites with useful and related information.

The Medi-Cal Dental website provides access to:

- Provider and Electronic Data Interchange (EDI) enrollment descriptions and forms
- Access to resource links
- Publications, such as bulletins and Handbook updates
- Seminar schedules
- The provider referral list
- Information related to billing criteria
- Outreach services
- Managed care
- Frequently asked questions

The Medi-Cal website allows providers to:

- Access eligibility
- Perform Share of Cost (SOC) transactions

More information about SOC can be found in "Section 4: Treating Members" of this Handbook.

Email

Providers can now subscribe to the Medi-Cal Dental Fee-for-Service Provider email distribution list to receive updates related to Medi-Cal Dental. A registration form is available on the Medi-Cal Dental website here. Providers may unsubscribe from the email list at any time.

Training Program

Medi-Cal Dental offers an extensive training program that has been designed to meet the needs of both new and experienced providers and their staffs.

Seminars

Medi-Cal Dental conducts basic and advanced seminars statewide. Seminar attendees receive the most current information on all aspects of Medi-Cal Dental. Basic seminars address general program purpose, goals, policies, and procedures; provide instructions for the correct use of

standard billing forms; and explain the reference materials and support services available to Medi-Cal dental providers. The expanded format of the advanced seminars offers in-depth information on topics such as Medi-Cal Identification Cards; dental criteria; radiograph and documentation requirements; processing codes; and other topics of specific concern to Medi-Cal dental providers.

In addition to the regular basic and advanced seminars scheduled each quarter, Medi-Cal Dental conducts workshops and orthodontic specialty seminars throughout the year. The uniquely designed workshops give inexperienced billing staff a "hands-on" opportunity to learn about Medi-Cal Dental and practice their newly acquired skills. Specialized training seminars have been developed for orthodontists who participate in the Medi-Cal Dental Orthodontic Services Program; these intensified sessions cover all aspects of the orthodontic program, including enrollment and certification, completion of billing forms, billing procedures and criteria and policies specific to the provision of Medi-Cal dental orthodontic services.

Each Medi-Cal Dental training seminar is conducted by an experienced, qualified instructor.

Continuing education credits for all seminars are offered to dentists and registered or certified dental assistants and hygienists. Medi-Cal Dental training seminars are offered free of charge at convenient times and locations.

Although there are no prerequisites for attendance at any type of seminar, for Medi-Cal Dental to continue offering free provider training seminars and workshops, making reservations well in advance is recommended. If unable to keep the reservation, please notify Medi-Cal Dental promptly. Space is limited and "no-shows" prevent others from being able to attend. Seminar schedules are available on the Medi-Cal Dental website here.

On-Site Visits

Providers needing assistance may request an on-site visit by a Provider Relations Representative by phoning the Telephone Service Center at (800) 423-0507. This personal attention is offered to help the provider and office staff better understand Medi-Cal Dental policies and procedures to easily meet program requirements.

Provider Appeals Process

The three separate, specific procedures for asking Medi-Cal Dental to reevaluate/appeal the denial or modification of a claim payment or a TAR authorization are as follows:

1. Submitting a Claim Inquiry Form (CIF)
2. Reevaluation of a Notice of Authorization (NOA)
3. First–Level appeal

To find out why payment of a claim was disallowed or to furnish additional information to Medi-Cal Dental for reconsideration of a payment denial or modification, the provider should

begin by submitting the Claim Inquiry Form (CIF) within six calendar months of the Explanation of Benefits (EOB) date. Please refer to "Section 6: Forms" of this Handbook for guidelines for submitting a CIF. Check the box on the CIF marked "CLAIM REEVALUATION ONLY." Remember to send a separate CIF for each inquiry.

Use the Notice of Authorization (NOA) to request a single reevaluation of modified or disallowed procedures on a TAR. Check the "Reevaluation is Requested" box in the upper right corner of the NOA. Do not sign the NOA when requesting reevaluation. Include any additional documentation for reconsideration and return the NOA to Medi-Cal Dental. Reevaluations may be requested only once.
In "Section 6: Forms" of this Handbook, the complete procedures are listed for requesting reevaluation of a TAR using the NOA.

If upon reconsideration Medi-Cal Dental upholds the original decision to disallow payment of the claim or authorization of treatment, the provider may request an appeal. In accordance with Title 22, Section 51015, of the California Code of Regulations (CCR), Medi-Cal Dental has established an appeals procedure to be used by providers with complaints or grievances concerning the processing of Medi-Cal Dental TAR/Claim forms for payment. The following procedures should be used by dentists to appeal the denial or modification of a TAR or claim for payment of services provided under Medi-Cal Dental.

Provider First-Level Appeals

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

Medi-Cal Dental will acknowledge the written complaint or grievance within 21 calendar days of receipt. The complaint or grievance will be reviewed by Medi-Cal Dental Provider Services, and a report of the findings and reasons for the conclusions will be sent to the provider within 30 days of the receipt of the complaint or grievance. If review by Provider Services determines it necessary, the case may be referred to Medi-Cal Dental Professional Review.

If the complaint or grievance is referred to Medi-Cal Dental Professional Review, the provider will be notified that the referral has been made and a final determination may require up to 60 days from the original acknowledgement of the receipt of the complaint or grievance. Professional Review will make its evaluation and send findings and recommendations to the provider within 30 days of the date the case was referred to Professional Review.

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

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.

Health Insurance Portability and Accountability Act (HIPAA) and the National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers, as well as the adoption of standard unique identifiers for health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. NPPES collects identifying information on health care providers and assigns each a unique National Provider Identifier (NPI) number.

The NPI is a unique 10-digit number, used across the country to identify providers to health care partners, regardless of type of practice or location. All public and private health plans are required by HIPAA to receive/submit the NPI as the only provider identifier in all electronic transactions.

It is required for use in all HIPAA transactions:

- Health care claims
- Claim payment/remittance advice
- Coordination of benefits
- Eligibility inquiry/response
- Claim status inquiry/response
- Referrals
- Enrollment

Information on how to apply for an NPI can be found here.

Registering NPIs

All NPIs (both billing and rendering providers) must be registered with Medi-Cal Dental to ensure appropriate payment of claims in a timely manner. Providers may register their NPIs through one of three options:

1. Submitting a hardcopy registration form (DHCS 6218) by mail, or
2. Calling the Medi-Cal Dental Telephone Service Center at (800) 423-0507, or
3. Register NPIs using the Medi-Cal Dental Web Collection System on the Medi-Cal Dental website.

Rendering providers who have not submitted a Social Security Number to Medi-Cal Dental at the time of enrollment will not be able to register using the Medi-Cal Dental Website. Such providers will need to register using the Medi-Cal Dental NPI Registration Form (DHCS 6218) found on the Medi-Cal Dental website.

Freedom of Information Act (FOIA)-Disclosable Data

NPPES health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the
e-FOIA Amendments, CMS has these data via the Internet. Data is available in two forms:

- A query-only database, known as the NPI registry
- A downloadable file

For more information on FOIA, visit the CMS website here.

Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is the
computer-to-computer transfer of transactions and information. Providers are encouraged to submit claims electronically for improved productivity and cost efficiency.

EDI enrollment and other important EDI information can be obtained by:

- accessing the EDI drop-down on the Medi-Cal Dental website here, or:
- sending an email to Medi-CalDentalEDI@delta.org, or:
- calling the Telephone Service Center at (800) 423-0507, or
- calling (916) 853-7373 and asking for EDI Support.

Enrollment requirements for EDI can be found in "Section 3: Enrollment Requirements" of this Handbook.

Providers using EDI for claims submissions are still required to provide radiographs and other attachments to Medi-Cal Dental. They can be sent either by mail or digitally through a certified electronic attachment vendor.

Providers who submit directly to Medi-Cal Dental are limited to five (5) EDI file submissions per day. Additional files will be rejected, and providers will need to resubmit. There are no limitations on the number of documents contained in each file.

Digitized Images

In conjunction with claims and TARs submitted electronically, Medi-Cal Dental now accepts digitized radiographs and attachments submitted through electronic attachment vendors Change Healthcare, DentalXChange, National Electronic Attachment, Inc. (NEA), National Information Services (NIS), and Vyne .

Note: Providers must be enrolled in EDI to submit documents electronically prior to submitting digitized images. For more information see "Section 3: Enrollment Requirements" of this Handbook.

Overview of TAR and Claim Processing

In administering Medi-Cal Dental, Medi-Cal Dental's primary function is to process TARs and Claims submitted by providers for dental services performed for Medi-Cal recipients. It is the intent of Medi-Cal Dental to process TARs and Claims as quickly and efficiently as possible. A description of the processing workflow is offered to promote a better understanding of the Medi-Cal Dental automated claims processing system.

Document Control Number (DCN)

All incoming documents are received and sorted in the Medi-Cal Dental mail room. TARs and Claims are separated from other incoming documents, including general correspondence, and assigned a Document Control Number (DCN).

The DCN is a unique number containing 11 digits in the following format:

14 059 1 000 01

The first five digits of the DCN represent the Julian date of receipt. In the example shown above, "14" designates the year, and "059" designates the fifty-ninth day of that year. The sixth digit, "1," identifies the type of document: 1 = TAR/Claim form. The remaining five digits of the DCN represent the sequential number assigned to the document. Thus, the document assigned

the DCN shown in the example above would be the first TAR or Claim received by Medi-Cal Dental on the fifty-ninth day of 2014 or February 28, 2014.

TARs and Claims plus any attachments are then scanned, batched, and forwarded to Data Entry, where pertinent data from the forms is entered into the automated claims processing system.

Edits and Audits

After data from the TAR or Claim is scanned into the system, the information is automatically edited for errors. Errors are highlighted on a display screen, and the data entry operator validates the information entered against the scanned image. When necessary corrections are made and the operator confirms that the information scanned is correct, the system prompts the operator as to the proper disposition of the TAR or Claim.

TAR/Claim Adjudication

Information on a TAR or Claim is audited via a series of manual and automated transactions to determine whether the services listed should be approved, modified, or disallowed. If the claim data is determined to be satisfactory, the result is payment, with the issuance of an EOB and a check.

If the TAR data is determined to be satisfactory, the result is authorization of treatment, with the issuance of a NOA.

If the information submitted on the TAR or Claim is not sufficient, the document is held for further manual review until a resolution can be concluded. In some instances, more information may be required to make a determination. Medi-Cal Dental will issue a Resubmission Turnaround Document (RTD) to request additional information from the provider.

Radiographs

Radiographs should be taken only for clinical reasons as determined by the member's dentist. Radiographs are part of the member's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

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Radiographs and photographs will not be returned.

Prior Authorization

Prior authorization is required for some Medi-Cal dental benefits. For detailed information regarding procedures requiring prior authorization, please refer to "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Following is a list of Medi-Cal dental procedures requiring prior authorization:

Restorative

D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791

Endodontics

D3222, D3310*, D3320*, D3330*, D3346*, D3347*, D3348*, D3351, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3921
*Age 21 and older

Periodontics

D4210, D4211, D4260, D4261, D4341, D4342, D4999

Prosthodontics (Removable)

D5110, D5120, D5211, D5212, D5213, D5214, D5863, D5865, D5899 (non-emergency)

Maxillofacial Prosthetics

D5937, D5958, D5986, D5988, D5999 (non-emergency)

Implant Services

D6010, D6013, D6040, D6050, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6082, D6086, D6090, D6091, D6094, D6095, D6098, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6121, D6191, D6192, D6194, D6199

Fixed Prosthodontics

D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D6999

Oral & Maxillofacial Surgery

D7280, D7283, D7290, D7340, D7350, D7840, D7850, D7852, D7854, D7858, D7860, D7865, D7872, D7873, D7874, D7875, D7876, D7877, D7880, D7899
(non-emergency), D7940, D7941, D7943, D7944, D7945, D7950, D7951, D7952, D7955, D7991, D7993, D7994, D7995

Orthodontics

D8080, D8210, D8220, D8660, D8670, D8680, D8696**, D8697**, D8701**, D8702**, D8703**, D8704**, D8999 (non-emergency)
**Transfer cases only

Adjunctive Services

D9222, D9223, D9239, D9243, D9950, D9952, D9999 (non-emergency)

Dental services provided to patients in hospitals, skilled nursing facilities, and intermediate care facilities are covered under Medi-Cal Dental only following prior authorization of each non-emergency and non-diagnostic dental service (Section 51307(f)(3), Title 22, California Code of Regulations). Emergency services may be performed on convalescent patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. However, the provider must submit clinical information with the claim describing the member's condition and the reason the emergency services were necessary.

Medi-Cal Dental, within the Department, and California Code of Regulations (CCR), Title 22, Section 51455, state that prior authorization may be required of any or all providers for any or all covered benefits of the program except those services specifically exempted by Section 51056(a) and (b). These prior authorization requirements do not change when the member has other dental coverage; the provider should submit for prior authorization and indicate the primary carrier. No verbal authorization will be granted by Medi-Cal Dental. Medi-Cal Dental reserves the right to require prior authorization in accordance with these guidelines.

Election of Prior Authorization

If a provider chooses to submit a TAR for services that do not normally require prior authorization, Medi-Cal Dental may not review these procedures. However, these services may be reviewed if they are submitted as part of a total treatment plan. When a provider receives a NOA for procedures on a TAR that do not normally require prior authorization, the NOA is not a guarantee that these procedures have been approved. (Refer to "Section 7: Codes", Adjudication Reason Codes 355A, 355B, and 355C.)

If a provider elects to have any proposed treatment plan prior authorized, all provisions relating to prior authorization for all services listed apply.

Non-Transfer of Prior Authorization

Prior authorization is not transferable from one provider to another. If for some reason the provider who received authorization is unable to complete the service or the member wishes to go to another provider, another provider cannot perform the service until a new treatment plan is authorized under his/her own provider number.

To expedite processing of a TAR with a change of provider, submit a new TAR with an attached statement from the member indicating a change of provider.

Retroactive Prior Authorization

Title 22, Section 51003, State of California Code of Regulations (CCR) allows for the retroactive approval of prior authorization under the following conditions:

- When certification of eligibility was delayed by the county social services office;
- When member's other dental coverage denied payment of a claim for services;
- When the required service could not be delayed;
- When a member does not identify himself/herself to the provider as a Medi-Cal member through deliberate concealment or because of physical or mental incapacity to identify himself/herself. The provider must submit in writing that concealment occurred, and the submission of the TAR must be within 60 days of the date the provider certifies he/she was made aware of the member's eligibility.

Clinical Screening

During the processing of the TAR, Medi-Cal Dental may decide to further evaluate the member and schedule a clinical screening appointment.

If this occurs, the dental office will receive a letter notifying them that a screening will take place and the member will be sent a screening notification appointment letter. Clinical Screening Dentists, acting as members of the program's Quality Assurance Committee, serve as impartial observers to examine patients and report their objective clinical findings. Medi-Cal Dental utilizes these observations as additional information to help in making a final determination of medical necessity or the appropriateness and/or quality of care.

Screening protocol dictates that the Clinical Screening Dentist is not allowed to discuss their clinical observations with providers, patients, or any third party. In addition, providers or the member's representatives are not allowed to accompany the member to a screening. To ensure attendance, it is also recommended that providers fully discuss proposed treatment with their patients before a clinical screening appointment. Failure to do so may result in a potential delay or denial of treatment.

Billing and Payment Policies

Billing Members

Providers may not submit a claim to, or demand or otherwise collect reimbursement from, a Medi-Cal member, or from other persons on behalf of the member, for any service (other than Share of Cost). Section 51002 of Title 22 of the California Code of Regulations specifically prohibits billing or collecting from Medi-Cal members for services included in Medi-Cal Dental scope of benefits, except for those patients who have a fiscal liability to obtain and/or maintain eligibility requirements.

In addition, Title 42, Volume 3, of the Code of Federal Regulations, reads as follows:

Section 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible or coinsurance required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with Sec. 431.55(g) or Sec. 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

Finally, Welfare & Institutions Code reads:

14107.3 Any person who knowingly and willfully charges, solicits, accepts, or receives, in addition to any amount payable under this chapter, any gift, money, contribution, donation, or other consideration as a precondition to providing services or merchandise to a Medi-Cal member for any service or merchandise in the Medi-Cal's program under this chapter or Chapter 8 (commencing with Section 14200), except either:

(1) To collect payments due under a contractual or legal entitlement pursuant to subdivision (b) of Section 14000; or

(2) To bill a long-term care patient or representative for the amount of the patient's share of the cost; or

(3) As provided under Section 14019.3, is punishable under a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not to exceed ten thousand dollars ($10,000), or both such imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment in the state prison.

<u>This clause means that a provider may not bill both the member and the program for the same Medi-Cal dental procedure</u>. If the provider submits a claim to Medi-Cal Dental, he/she can't bill the member for the difference between Medi-Cal Dental's Schedule of Maximum Allowances (SMA) and the provider's usual, customary, and reasonable (UCR) fee.

If Medi-Cal eligibility is verified, the provider may not treat the member as a private-pay member to avoid billing Medi-Cal Dental, obtaining prior authorization (when necessary) or complying with any other program requirement. In addition, upon obtaining eligibility verification, the provider cannot bill the member for all or part of the charge of a Medi-Cal covered service except to collect the share of cost. Providers cannot bill members for private insurance cost-sharing amounts such as deductibles or co-insurance

This clause means that once a provider has checked a member's eligibility, or has submitted a claim or TAR for services, then that provider has agreed to accept that member as a Medi-Cal

dental member and can't later decide to not accept the member for treatment to avoid pre-authorization requirement or having to accept Medi-Cal dental fees. The provider also agrees not to charge the member for all or part of any treatment that has been deemed by Medi-Cal Dental to be a covered benefit.

A provider and member may enter into a private agreement under the following scenarios:

a. The provider and member have agreed to have specific dental treatment performed outside of Medi-Cal Dental. The provider must have not verified the member's eligibility or submitted any TAR or claim to Medi-Cal Dental for the current phase of treatment.

Or:

b. The provider has submitted a specific procedure on a TAR or claim to Medi-Cal Dental that was subsequently denied on the basis that it was either not a benefit under Medi-Cal Dental's scope of benefits or it was denied because it did not meet the medically necessary criteria of the program or time/frequency limitations for the specific procedure. Procedures that have been denied for technical or administrative reasons, such as failure to respond to Resubmission Turnaround Documents (RTDs), inadequate radiograph submission, signatures, or that the procedure is included in a global procedure billed, cannot be billed to the member under any circumstances.

Providers should establish written contracts with members before any non-reimbursed Medi-Cal Dental treatment is rendered. They should also secure the proper Medi-Cal Dental denial if applicable.

Providers cannot bill a Medi-Cal dental member for broken appointments (42 CFR 447.15 and SSA 1902 (a)(19).

When members request copies of records and/or radiographs, providers can charge them a reasonable fee for duplication, but only when they have the same policy for their private patients.

Providers may only bill members their UCR fees if the $1,800 limit per calendar year for member services (dental soft cap) has been met and nothing has been paid on a procedure.

Providers may not bill members when the program has paid any amount on a specific procedure as the result of the member soft cap being met. This partial payment on a procedure must be considered payment in full.

Member Reimbursements

In accordance with Welfare and Institutions Code Section 14019.3, a Medi-Cal dental provider is required to reimburse a Medi-Cal dental member who paid for a medically necessary covered service rendered by the provider during any of the following three time periods: 1) the 90-day period prior to the month of application for Medi-Cal Dental; 2) the period after an application

is submitted but prior to the issuance of the member's Medi-Cal card; and 3) after issuance of the member's Medi-Cal card for excess co-payments (i.e., co-payments that should not have been charged to the member).

By law, a Medi-Cal dental provider must reimburse a member for a claim if the member provides proof of eligibility for the time period during which the medically necessary covered service was rendered (and for which the member paid). Evidence of the reimbursement paid by the provider to the member should be submitted to Medi-Cal Dental as a claim with the appropriate documentation to indicate that Medi-Cal Dental eligibility was recently disclosed. The Department will allow the provider a timeliness override in order to bill Medi-Cal Dental for the repaid services. If the provider does not reimburse the member, the member may contact the Department, inform the Department of the provider's refusal to reimburse, and then submit a request for reimbursement directly to the Department. In this case, the Department will contact the provider and request that the provider reimburse the member. Should the provider refuse to cooperate, the Department will reimburse the member for valid claims and recoup the payment from the provider. Additional sanctions may be imposed on the provider such as those set forth in Welfare and Institutions Code Section 14019.3.

A new law, Senate Bill (SB) 639, effective July 1, 2020, specifies in Business and Professions (B&P) Code, if a dental provider accepts Medi-Cal, the treatment plan for a Medi-Cal patient shall indicate if Medi-Cal would cover an alternate, medically necessary service as defined in current law, WIC Section 14059.5. The treatment plan shall indicate that the Medi-Cal patient has a right to ask for only services covered by Medi-Cal and that the dental provider agrees to follow Medi-Cal rules to secure Medi-Cal covered services before treatment.

The law currently states:

- Dentists shall not charge to third-party lines of credit (arranged for or established in their office) any treatment costs before the treatments are provided, unless the dentist provides the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs. [B&P Code § 654.3(b)].
    - The written treatment plan must include:
        - Each anticipated service to be provided and the estimated cost of each service;
        - The patient's private or government-estimated share of cost for each service (if applicable, including whether Medi-Cal will cover the service); and
        - If services are not covered by patient's private or other insurance (including Medi-Cal), notification that the services may not be covered, and that the patient has the right to confirm coverage before starting dental treatment.

Written notice must be provided in patient's threshold language. [B&P Code § 654.3(f)].

Changes to the law effective July 1, 2020:

- Dentists shall provide the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs.
    - The notice must include the revised language specified in B&P Code § 654.3(g).
    - For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment. [B&P Code § 654.3(h)(1)].

Not a Benefit/Global

Dental or medical health care services that are not covered by the Medi-Cal program are deemed "not a benefit."

"Global procedures" are those procedures that are performed in conjunction with, and as part of, another associated procedure. Global procedures are not separately payable from the associated procedure.

Dental Materials of Choice

Medi-Cal Dental wants all providers to understand the important distinction between a member's entitlement to a medically necessary covered dental service and your professional judgment of which dental material is used to perform the service.

In general, a Medi-Cal dental member is entitled to covered services that are medically necessary. The choice of dental material used to provide a specific service lies within the scope of the professional judgment of the dentist.

Providers may not bill members for the difference between the Medi-Cal Dental fee for covered benefits and the UCR fee.

Payment Policies

Medi-Cal Dental will only pay for the lowest cost procedure that will correct the dental problem. For example, Medi-Cal Dental cannot allow a porcelain crown when a restoration would correct the dental problem. A dental office cannot charge Medi-Cal Dental more than it charges a private member for the services performed. The dental office should list its UCR fees when filling out the claim, TAR or NOA, not the SMA.

For tax purposes, Medi-Cal Dental uses Form 1099 to report earnings to the Internal Revenue Service (IRS) for each billing provider who has received payment from Medi-Cal Dental during

the year. Federal law requires that Medi-Cal Dental mail 1099 forms by January 31 of each year to reflect earnings from January 1 through December 31 of the previous year.

It is the provider's responsibility to make certain Medi-Cal Dental has the correct billing provider name, address and Taxpayer Identification Number (TIN) or Social Security Number (SSN) that correspond exactly to the information the IRS has on file. If this information does not correspond exactly, Medi-Cal Dental is required by law to apply a 28 percent withholding to all future payments made to the billing provider. To verify how tax information is registered with the IRS, please refer to the preprinted label on IRS Form 941, "Employer's Quarterly Federal Tax Return," or any other IRS-certified document. The provider may also contact the IRS to verify how a business name and TIN or SSN are recorded.

If a provider does not receive the 1099 form, or if the tax or earnings information is incorrect, please contact Medi-Cal Dental at (800) 423-0507 for the appropriate procedures for reissuing a correct 1099 form.

Assistant Surgeons

Assistant surgeons should bill Medi-Cal Dental using Procedure D6199/D7999 (as applicable) and may be paid 20% of the surgical fee paid to the primary surgeon (dentist or physician) provided the following is submitted with the claim:

- The operating report containing the name of the assistant surgeon;
- Proof of payment to the primary surgeon.

Surgical fees include major maxillofacial and orthognathic procedures, as well as trauma surgery, and include all associated extractions. All other procedures (anesthesia, radiographs, restorations, etc.) performed on the same date of service as the surgical procedure including bedside visits and hospital care are not considered in the determinations of the surgical fee and are not payable to assistant surgeons.

Providing and Billing for Anesthesia Services

Prior Authorization is required for general anesthesia (GA) and intravenous (IV) sedation. A TAR can only be requested from an enrolled Medi-Cal Dental provider. The anesthesiologist may submit a TAR if they are enrolled as a billing provider. If an anesthesiologist is not a billing provider, the billing provider rendering the dental services may submit the TAR on behalf of the anesthesiologist rendering the anesthesia. Additionally, if an anesthesiologist is part of a group practice, the group practice may submit a TAR on behalf of anesthesiologist.

Note: Prior authorization is not required for a member who resides in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled.

The provider must submit a documentation indicated below to justify the medical necessity for anesthesia services.

If the provider provides clear medical record documentation of both number 1 and number 2 below, then the patient shall be considered for intravenous sedation or general anesthetic:

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.
2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for intravenous sedation or general anesthetic:

3. Use of effective communicative techniques and immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.
4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due a lack of psychological or emotional maturity that inhibits the ability to appropriately respond to commands in a dental setting.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

Prior authorization can be waived when Intravenous Sedation/General Anesthesia is medically necessary to treat an emergency medical condition. An "emergency medical condition" is defined in Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, Section 51056 (b).

Billing providers must ensure that all their rendering dental anesthesiologists and dentists providing general anesthesia and intravenous conscious sedation/analgesia are permitted or certified through the Dental Board of California prior to enrolling in Medi-Cal Dental and prior to treating Medi-Cal patients (B&P Code 1646.1and 1647.19-20). Payments made to billing providers for services performed by their unenrolled rendering providers will be subject to payment recovery per Title 22, Section 51458.1 (a)(6).

The following is required to receive payment for administering general anesthesia or intravenous conscious sedation/analgesia:

- The rendering provider performing the general anesthesia must have a valid permit with the Dental Board of California and the permit number must be on file with Medi-Cal Dental.
- The anesthesia record must be signed by the anesthesiologist performing the anesthesia procedure. The rendering provider name on the anesthesia record must coincide with the rendering provider number in field 33 on the claim for payment.

Tamper-Resistant Prescription Pads

For Medi-Cal Dental outpatient drugs to be reimbursable by the federal government, all written, non-electronic prescriptions must be executed on tamper-resistant pads. The tamper-resistant prescription pad requirement applies to over-the-counter drugs and impacts all dentists and other providers who prescribe outpatient drugs.

The Centers for Medicare and Medicaid Services (CMS) has issued guidance on this requirement that can be found on the website here.

As outlined by CMS, a prescription pad must contain at least one of the following three characteristics and, by October 1, 2008, all three characteristics:

7. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
8. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or,
9. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The National Council for Prescription Drug Programs (NCPDP) has issued a letter providing additional information as to which tamper-resistant features fall within the three characteristics, a copy of which can be found on the Medi-Cal website.

The California-required tamper-resistant prescription pads for controlled drugs fully meet the federal compliance requirements. Prescribers are encouraged to use the current pads and may order tamper-resistant prescription pads from security prescription printer companies.

Those companies preapproved by the California Department of Justice and Board of Pharmacy to produce tamper-resistant prescription pads are listed here. This directory provides an alphabetical listing of companies and is updated as new security prescription printers are approved. Providers will need their prescriber's state license number and a copy of their DEA Registration when they place their order. Other security prescription printer companies are available and may be used as needed. To comply with California statute, regardless of how a provider chooses to procure tamper-resistant prescription pads for all other written Medi-Cal prescriptions, providers must continue to procure tamper-resistant prescription pads for controlled drugs from the list of approved security prescription printer companies.

Time Limitations for Billing

Time limitations for billing services provided under Medi-Cal Dental are governed by Section 14115 of the Welfare and Institutions Code. Claims received by Medi-Cal Dental within:

- Six calendar months after the end of the month in which the service was performed are considered for full payment (100 percent of the SMA).

- Seven to nine months after the end of the month in which the service was performed will be considered for payment at 75 percent of the SMA amount.
- Ten to twelve months after the end of the month in which the service was performed will be considered for payment at 50 percent of the SMA amount.

The time limitation for billing will be applied to each date of service.

Medi-Cal Dental may receive and process late claims upon review of substantiating documentation that justifies the late submittal of a claim. The following is a list of reasons delayed submissions are acceptable when circumstances are beyond the control of the provider:

1. A member did not identify himself/herself to a provider as a Medi-Cal member at the time services were performed. The provider must submit the claim for payment within 60 days after the date certified by the provider that the member first did identify himself/herself as a Medi-Cal member. The date so certified on the claim must be no later than one year after the month in which services were performed.
2. The maximum time period for submission of a claim involving other coverage is one year from the date of service, to allow sufficient time for the provider to obtain proof of payment or
   non-liability of the other insurance carrier.
3. If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, Medi-Cal Dental may extend the period of submission to one year from the date of service. Title 22, Section 51008, lists those specific circumstances which would be considered beyond the control of the provider and under which such an extension may be granted:
   - delay or error in the certification or determination of Medi-Cal eligibility by the State or county;
   - delay in delivering a completed removable appliance when a member does not return in a timely manner for delivery (Section 51470(b) states an undelivered, custom-made prosthesis must be retained for no less than one year after the date it was ordered, and is payable at 80% of the amount after the provider has attempted to deliver the prosthesis to the member);
   - damage to or destruction of provider's business office or records by natural disaster, including fire, flood, or earthquake; or circumstances involving such a disaster that have substantially interfered with the timely processing of bills;
   - delay of required authorization by Medi-Cal Dental;
   - delay by Medi-Cal Dental in supplying billing forms to the provider;
   - theft, sabotage, or other deliberate, willful acts by an employee;
   - other circumstances, clearly beyond the control of the provider that have been reported to the appropriate law enforcement or fire agency, where applicable;

- special circumstances, such as court or fair hearing decisions.

Interim Payments

Interim payments are made to Medi-Cal dental providers for unpaid claims that have been delayed at least 30 days due to Medi-Cal Dental or State errors, or for paid claims affected by retroactive changes.

A provider may contact Medi-Cal Dental, either by telephone or in writing, to request interim payment. Medi-Cal Dental will determine if a claim qualifies for interim payment. If it does not qualify, or if a determination cannot be made, Medi-Cal Dental must notify the provider by telephone within 24 hours, followed by a written notice within two workdays. If Medi-Cal Dental determines that a claim does qualify for interim payment, the findings are forwarded to the State for final approval or denial of the request.

When the State reaches a final decision, it will notify Medi-Cal Dental.

Medi-Cal Dental, in turn, will notify the provider. Once final approval of interim payment has been received from the State by Medi-Cal Dental, the payment request is processed, and a check is generated and sent to the provider.

Retroactive Reimbursement for Medi-Cal Members for Out-of-Pocket Expenses

As a result of the Conlan v. Shewry court decision, a process has been implemented by which members can obtain prompt reimbursement of their Medi-Cal Dental covered, out-of-pocket expenses. For questions or instructions regarding this reimbursement, please phone the Conlan Help Desk at (916) 403-2007.

Medi-Cal Dental Responsibilities

Medi-Cal Dental responsibilities include the following:

- Verifying member Medi-Cal Dental eligibility
- Evaluating supporting medical expense documentation provided by the member
- Reviewing rendered services for medical necessity
- Determining whether Medi-Cal Dental payment was previously made
- Verifying that the provider reimbursed the member
- Maintaining documentation for each case

Provider Notification of Member Request for Reimbursement

If a member's request for reimbursement is validated by Medi-Cal Dental, a letter of request for member reimbursement is sent to the provider. This letter must be submitted with the provider's claim for reimbursement.

Provider Responsibility

Upon receipt of a member reimbursement letter, providers are expected to reimburse members for monies that the member paid to the provider at the time of service, then submit a claim to Medi-Cal Dental. Claims will be denied if the member has not been reimbursed.

Claim Submission

Providers must submit claims to Medi-Cal Dental within 60 days of the date on the letter as follows:

- Submit an original hard-copy claim solely for services mentioned in the member reimbursement letter
- Attach the member reimbursement letter
- Attach any additional required Medi-Cal Dental documentation

The original claim, member reimbursement letter, and supporting documentation should be submitted to the following address:

Medi-Cal Dental
Attn: Member Services
PO Box 526026
Sacramento, CA 95852-6026

No electronic claim submission is allowed. Medi-Cal Dental determines medical necessity; therefore, no TAR is required. The six-month billing limit will be waived for these claims.

Provider Reimbursement

Providers are reimbursed for medically necessary services according to the current SMA found in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

To be reimbursed, the provider must have been enrolled as a Medi-Cal dental provider on the date of service. Providers should contact Medi-Cal Dental at (800) 423-0507 if any of the following conditions apply:

- Provider was not a Medi-Cal dental provider on the date of service but wants to enroll now
- Provider is a Medi-Cal dental provider now but was not enrolled on the date of service and needs retroactive eligibility

- Provider was not a Medi-Cal dental provider on the date of service but wants to temporarily enroll retroactively in Medi-Cal Dental in order to bill for the Member Reimbursement Process claims

For more information on Provider Enrollment, please refer to "Section 3: Enrollment Requirements" of this Handbook.

Medicare/Medi-Cal Crossover Claims

Medicare will pay for the following dental services: D0502, D5924, D5931, D5932, D5934, D5935, D5936, D5999, D7285, D7286, D7450, D7451, D7460, D7461, D7465, D7490, D7610, D7620, D7630, D7640, D7650, D7660, D7680, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7780, D7810, D7820, D7830, D7840, D7850, D7852, D7854, D7856, D7858, D7860, D7865, D7870, D7872, D7873, D7874, D7875, D7876, D7877, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7981, D7982, D7991, D7995, D7997.

Please note that the following codes listed above require prior authorization: D5999 (non-emergency), D7840, D7850, D7852, D7854, D7858, D7860, D7865, D7872, D7873, D7874, D7875, D7876, D7877, D7940, D7941, D7943, D7944, D7945, D7950, D7955, D7991, D7995.

If a TAR/Claim is submitted for a Medi-Cal dental member and Field 31 contains any of the procedure codes listed above, the claim or TAR must be accompanied by official documentation which clearly shows proof of payment/denial by Medicare or states the member's ineligibility. Documentation of ineligibility may be:

1. An Explanation of Medicare Benefits (EOMB) stating "No Part B coverage";
2. An EOMB stating "Benefits are exhausted";
3. An official document verifying the member's alien status;
4. An EOMB or any official document from the Social Security Administration verifying member's ineligibility for Medicare.

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

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

For information about Medicare enrollment and billing procedures, please visit the Noridian Healthcare Solutions website.

When processing a claim with Medicare covered services, Medi-Cal Dental reviews the EOMB submitted with the claim. The Medicare procedures listed on the EOMB are matched with the Medi-Cal Dental procedures listed on the claim. Payment calculations are based on Medicare deductibles, coinsurance, and Medi-Cal allowable amounts up to the SMA.

Orthodontic Services Program

The provision of medically necessary orthodontic services is limited to Medi-Cal and California Children's Services (CCS) eligible individuals under 21 years of age by dentists qualified as orthodontists under the California Code of Regulations, Title 22, Section 51223(c). For additional information, see "Section 9: Special Programs" of this Handbook.

Dental Restorations for Children Under Age Four and for Developmentally Disabled Members of Any Age

Senate Bill (SB) 1403 (Chapter 61, signed July 7, 2006), stipulates that "For any member who is under four years of age, or who, regardless of age, has a developmental disability, as defined in subdivision (a) of [Welfare and Institutions Code] Section 4512, radiographs or photographs that indicate decay on any tooth surface shall be considered sufficient documentation to establish the medical necessity for treatment provided."

Claims, NOAs, and CIFs with dates of service on or after January 1, 2007, and any TAR or reevaluation requiring review, will only require one radiograph or photograph that demonstrates medical necessity to be submitted. When the radiograph or photograph demonstrates at least one decayed surface, all of the fillings and prefabricated crowns on that document will be allowed, unless the member's history indicates the tooth has been previously extracted, a recent filling/prefabricated crown, etc.

Providers who are replacing fillings or prefabricated crowns that they previously placed must submit a current radiograph or photograph of that tooth that demonstrates the need for replacement when the applicable time limitations have not been met.

- When no radiographs or photographs are submitted, or when the single radiograph or photograph that is submitted is not current or is non-diagnostic, all fillings and prefabricated crowns on that document will be denied/disallowed.
- When there is no decay evident in the single radiograph or photograph submitted, all restorations will be denied/disallowed.
- When a pulpotomy is requested in conjunction with a filling/prefabricated crown, and the filling/prefabricated crown is denied/disallowed, the pulpotomy will also be disallowed.

Children Under Age Four

The member must be under the age of four at the time the services were rendered or when the request for authorization was reviewed.

Developmentally Disabled (DD) Members

Senate Bill (SB) 1403 (Chapter 61, signed July 7, 2006), amends Section 14132.88 of the Welfare and Institutions (W & I) Code and stipulates that for any member who is under four years of age, or who, regardless of age, has a developmental disability, as defined, radiographs or photographs that indicate decay on any tooth surface shall be considered sufficient documentation to establish the medical necessity for treatment provided.

Once a provider has established the fact that their member is a client of a Regional Center/ Department of Developmental Services, he/ she must document that fact on the document by writing the following – "Registered Consumer of the Department of Developmental Services." No substitute language or documentation will suffice.

When requesting authorization/payment of prefabricated crowns on permanent teeth for DD patients, the requirement for arch films will be waived.

Hospital (Special) 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., retardation, 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.

Hospital Inpatient Dental Services
(Overnight or Longer)

Inpatient dental services are defined as services provided to members residing in hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and those who are homebound.

Dental services provided to patients in hospitals are covered under Medi-Cal Dental only following prior authorization of each non-emergency and non-diagnostic dental service (Section 51307(f)(3), Title 22, California Code of Regulations). Emergency services may be performed on hospital patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. However, the provider must submit clinical information with the claim describing the member's condition and the reason the emergency services were necessary.

Inpatient dental services (hospitals, SNFs, and ICFs) are covered only when provided on the signed order of the provider responsible for the care of the member. A claim for inpatient dental services must show verification that the services are to be rendered on the signed order of the admitting physician or dentist.

If a Medi-Cal dental provider needs to perform dental services within a hospital inpatient setting, the provision of the medical support services, e.g., Operating Room (OR) time, surgical nurse, anesthesiologist, or hospital bed, will depend on how the Medi-Cal dental member receives their Medi-Cal medical services. Medi-Cal dental members may receive their medical services through a number of different entities:

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

Medi-Cal dental providers should refer to "Section 4: Treating Members" of this Handbook for instructions on how to determine the entity providing a member's medical services.

Prior authorization is required for each
non-emergency and non-diagnostic dental service provided to Medi-Cal dental members in a hospital inpatient setting where the member's hospital stay exceeds 24 hours. This authorization must be submitted on the Medi-Cal Form 50-1 and sent directly to this address:

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

The Medi-Cal Form 50-1 should not be submitted to Medi-Cal Dental as this will only delay the authorization for hospital admission.

For more information regarding the Medi-Cal TAR field offices, please review this document.

If the 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 Medi-Cal Form 50-1 retroactively within ten working days to the Medi-Cal field office.

A claim for payment of dental services is submitted to 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 surgicenter 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.

Homebound Patients (Place of Service 2)

A physician's letter is required when requesting dental services for a member who cannot leave his/her private residence due to a medical condition. The physician's letter must be on his/her professional letterhead with the following information documented:

- The member's specific medical condition
- The reason the member cannot leave the private residence
- The length of time the member will be homebound

Emergency services may be performed on homebound patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. In addition to the submission requirements for each individual procedure, the provider must also submit documentation with the claim describing the member's condition and the reason the emergency services were necessary. A letter from the member's physician, as stated above, must also be submitted with the claim.

Skilled Nursing and Intermediate Care Facilities (Place of Service 4 or 5)

The California Department of Public Health defines a Skilled nursing facility and Intermediate care facility as the following:

- Skilled nursing facility (SNF) means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Refer to California Health & Safety Code, Section 1250 for more details.
- Intermediate care facility (ICF) means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have a recurring need for skilled nursing

supervision and need supportive care, but who do not require availability of continuous skilled nursing care. Refer to California Health & Safety Code, Section 1250 for more details.

Providers may use the California Department of Public Health website to verify licensed facilities here.

All TARs and claims submitted for patients residing in SNFs or ICFs must include the following:

- Place of service 04 or 05 (only) must be indicated regardless of where the dental services were or will be performed.
- Facility name, phone number and address, regardless of where the dental services were or will be performed in Box 34 of the claim or TAR form.
- When treating residents outside of the facility, indicate the actual place of service in Box 34.

All procedures rendered on patients residing in an SNF or ICF require prior authorization except for the following emergency and diagnostic services.

D0120, D0145, D0150, D0210, D0220, D0230, D0240, D0250, D0270, D0272, D0274, D0330, D0340, D0350, D0502, D1110, D1120, D1206, D1208, D1320, D1556, D1557, D1558, D1999, D2940, D2941, D3221, D4355, D4910, D4920, D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5850, D5851, D6092, D6093, D7285, D7286, D7510, D7511, D7521, D9110, D9120, D9210, D9222, D9223, D9239, D9243, D9410, D9430, D9440, D9910, D9920, D9930, D9995, D9996.

Emergency services may be performed on SNF and ICF patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. In addition to the submission requirements for each individual procedure, the provider must also submit documentation with the claim describing the member's condition and the reason the emergency services were necessary.

To determine medical necessity and the member's adaptability and compliance with requested treatment, prior authorization requests may be evaluated by a Clinical Screening Dentist.

Note: Prior authorization will be waived for facility patients treated in a hospital or surgical center except for fixed partial dentures and removable prostheses and implants.

Hospital Care (Including Surgical Centers)
(Place of Service 6 or 7)

In a hospital setting, prior authorization for treatment included in the scope of benefits is not required except for laboratory processed crowns, fixed partial dentures, and implants. When treatment is performed without prior authorization (on a procedure that would normally require prior authorization), requests for payment must be accompanied by radiographs,

photographs, and any documentation to adequately demonstrate the medical necessity. Refer to the individual procedures for specific requirements and limitations. In addition, requests for payment must be accompanied by an operating room report that indicates the amount of time spent in the operating room suite.

Mobile Dental Treatment Vans
(Place of Service 8)

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.