Section 4 - Treating Members

Section 4 - Treating Members

Member Identification

Medi-Cal Benefits Identification Card

Medi-Cal Dental does not determine the eligibility of members. Eligibility for Medi-Cal Dental is determined by a County Social Services office and reported to the State of California. The State, in turn, issues a Medi-Cal Benefits Identification Card (BIC) to members who are eligible for Medi-Cal benefits. The BIC serves as a permanent identification for a Medi-Cal member; however, possession of the card does not guarantee eligibility for Medi-Cal benefits, since the card can be retained by the member whether or not the member is eligible for the current month.

For more information, please review the Eligibility: Recipient Identification Cards document.

BIC cards are 3 ⅛ inches long and 2 ⅜ inches wide with a white background. The lettering is blue on the front and black on the back. Printed on the front of the card is a 14-character alphanumeric identification (ID) number. The ID number is comprised of a nine-character alphanumeric, a check digit and a four-digit Julian date matching the issue date of the BIC.

Only California Children's Services (CCS) members will have a BIC with a 10-character ID. All other Medi-Cal members have received a BIC with a 14-character ID. If members have not received the 14-character BIC ID, refer them to their local county office.

Figure 4-1, "Poppy" Design

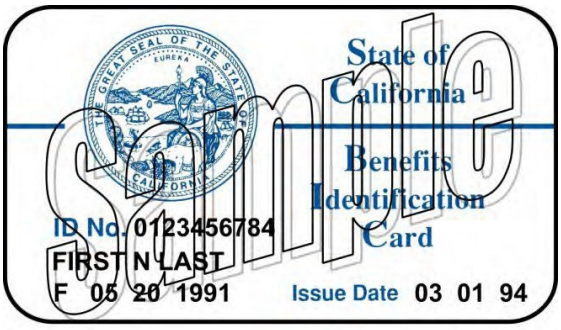


Figure 4-2, CCS Number (Numeric, 10 digit)

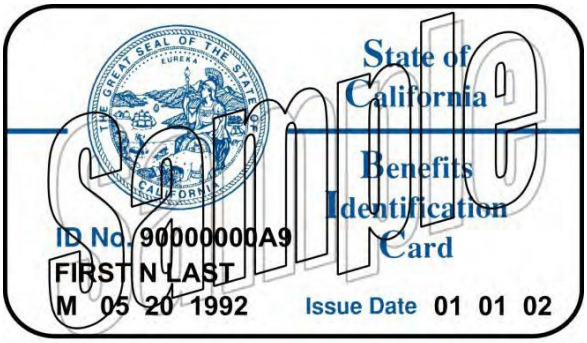


Figure 4-3, Pseudo SSN (Alphanumeric, 10 characters)

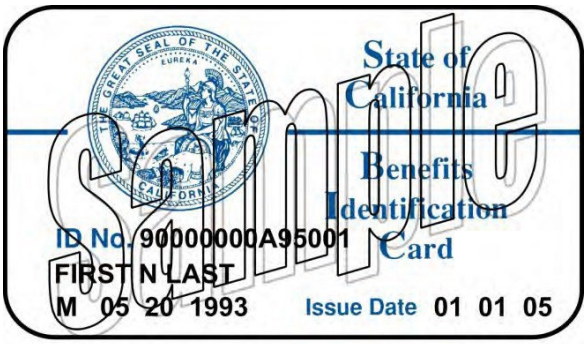


Figure 4-4, 14 Digit BIC Number (Alphanumeric, 14 characters)

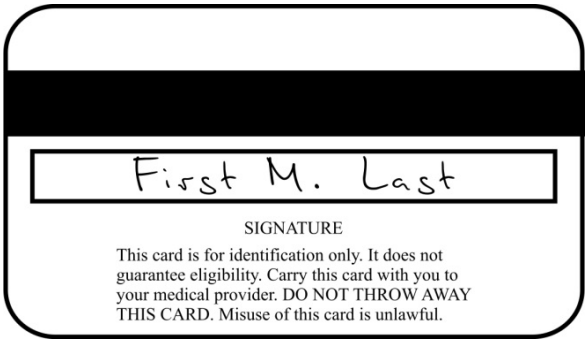


Figure 4-5, BIC (Back)

Special Programs Identification Cards

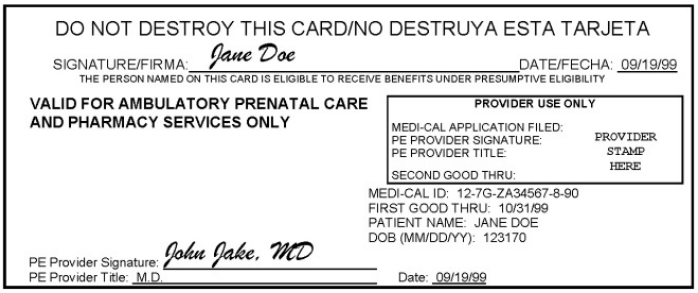
Some Medi-Cal members may be enrolled in special programs, such as prepaid health plans and pilot projects. A member enrolled in one of these plans who is eligible for dental services should have an identification card from the plan as well as possess a Medi-Cal Benefits Identification Card. A list of current special project and prepaid health plan codes can be found in "Section 9: Special Programs" of this Handbook.

Medi-Cal Identification Card for Presumptive Eligibility (MC 263 PREMEDCARD (4/96)) for Aid Code 7G

In order to receive payment for services provided to pregnant members in Aid Code 7G, providers must submit a copy of the member's temporary Presumptive Eligibility (PE)

card with their claim (see below for a sample of the card). The PE card is a required form of identification. Substitutions should not be accepted. This card is validated by the member's physician attending to the member's pregnancy and is valid until the Medi-Cal eligibility is determined or the PE period ends. This date is identified on the temporary PE card as the "First Good Thru" date. Some members may be eligible for extended PE coverage. In such cases, the temporary PE card will have a "Second Good Thru" date, and sometimes additional "Good Thru" dates. Once approved for Medi-Cal, the member will receive a plastic BIC.

Providers will only be paid for claims with dates of service that are between the effective date (the date the member signs the card) and the latest "Good Thru" date. The date of service must be within the validated time frame and, if not, providers should instruct the member to see a prenatal care provider, call an Eligibility Worker and/or a community advocate.


DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA

SIGNATURE/FIRMA: Jane Doe DATE/FECHA: 09/19/99

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY

VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY

PROVIDER USE ONLY

MEDI-CAL APPLICATION FILED:
PE PROVIDER SIGNATURE:
PE PROVIDER TITLE:
SECOND GOOD THRU:

PROVIDER STAMP HERE

MEDI-CAL ID: 12-7G-ZA34567-8-90
FIRST GOOD THRU: 10/31/99
PATIENT NAME: JANE DOE
DOB (MM/DD/YY): 123170

PE Provider Signature: John Jake, MD
PE Provider Title: M.D. Date: 09/19/99

Figure 4-6, Medi-Cal Identification Card Presumptive Eligibility

Immediate Need Cards

In certain situations, county welfare departments will issue Medi-Cal members temporary BICs to Immediate Need and Minor Consent Program recipients (see below for a sample of the card).

The ID number ("ID NO.") is the 14-character BIC ID: this is used to access the Medi-Cal Eligibility Verification System. Prior to rendering services, providers must verify the member's eligibility and that the member with the BIC is the individual to whom the card was issued.

Temporary BICs issued to Immediate Need recipients are valid for identification purposes for
30 days, as indicated on the "ISSUE DATE:" and "GOOD THRU:" lines. The valid dates may occur in two consecutive months and are only used for identification purposes. Providers must verify the member's eligibility before rendering services.

The temporary BICs received by Minor Consent Program recipients are valid for identification for one year. However, the recipient is only eligible for the requested month. The "Issue Date:" and "Good Thru:" dates are for identification purposes only: providers must still verify the member's eligibility before rendering services.

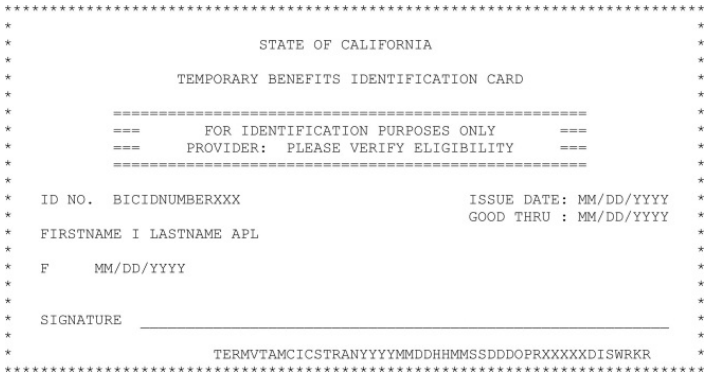


Figure 4-7, Immediate Need Card

Verifying Member Identification

In certain instances, no identification verification is required, for example:

- When the member is 17 years of age or younger.
- When the member is receiving emergency services.
- When the member is a resident in a long-term care facility.

If the member is unknown to the provider, the provider is required to make a “good-faith” effort to verify the member's identification by matching the name and signature on the Medi-Cal issued ID to that on a valid photo identification, such as:

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

The provider must retain a copy of this identification in the member's records. If there is a conflict in the member's Medi-Cal dental billing history where a provider bills or submits for authorization for a procedure that was previously performed by another provider, Medi-Cal Dental will request that the current provider submit a copy of the member's identification to verify that the services are being provided to the appropriate member. If this situation occurs and the current provider cannot provide appropriate member identification, payment, or authorization for treatment will be denied.

Please note: Medi-Cal dental providers must now accept expired photo identification (ID) up to six months from the date of expiration to verify a Medi-Cal patient’s eligibility. During this grace period, providers may not deny Medi-Cal patients service for an expired ID.

For additional information, please refer to Welfare & Institutions (W & I) Code 14017, 14017.5, 14018, and 14018.2(c).

Medi-Cal Dental Member Eligibility

A Medi-Cal member is eligible for dental services provided under Medi-Cal Dental. However, limitations or restrictions of dental services may apply in certain situations to the following individuals:

- Those enrolled in a prepaid health plan which provides dental services.
- Those enrolled in another pilot program which provides dental services.
- Those who are assigned special aid codes.
- Those with minor consent restricted service cards.

According to state law, when a provider elects to verify Medi-Cal eligibility using a BIC, a paper identification card or a photocopy of a paper card and has obtained proof of eligibility, he or she has agreed to accept the member as a Medi-Cal member and to be bound by the rules and regulations of Medi-Cal Dental.

Providers must verify eligibility every month for each recipient who presents a plastic Benefits Identification Card (BIC) or paper Immediate Need or Minor Consent card. Eligibility verified at the first of the month is valid for the entire month of service. An Internet eligibility response should be kept as evidence of proof of eligibility for the month. Eligibility may be verified only for the current month and up to the previous 12 months, never for future months.

A person is considered a child until the last day of the month in which his/her 18th birthday occurs. After that month, he/she is considered an adult. However, a treatment plan authorized for a child is effective until completion if there is both continuing eligibility and dental necessity, regardless of change in age status.

Members who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. Members who can make a mark (X) in lieu of a signature will not be exempted from this requirement and will be required to make their mark on the Medi-Cal identification card. In addition, the signature requirement does not apply when a member is receiving emergency services, is 17 years of age or younger, or is a member residing in a long-term care facility.

If Medi-Cal eligibility is verified, the provider may not treat the member as a private-pay member to avoid billing the member's insurance, 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 (SOC). Providers cannot bill members for private insurance cost-sharing amounts such as deductibles or co-insurance.

Once eligibility verification has been established, a provider can decline to treat a member only under the following circumstances:

- The member has limited Medi-Cal benefits and the requested service(s) is not covered by Medi-Cal Dental.
- The member is required to receive the requested service(s) through a designated health plan. This includes cases in which the member is enrolled in a Medi-Cal managed care plan or has private insurance through a health maintenance organization or exclusive provider network and the provider is not a member provider of that health plan.
- The provider is unable to provide the particular service(s) that the member requires.
- The member is not eligible for Medi-Cal dental services.
- The member is unable to present corroborating identification with the BIC to verify that he or she is the individual to whom the BIC was issued.

A provider who declines to accept a Medi-Cal member must do so before accessing eligibility information except in the above circumstances. If the provider is unwilling to accept an individual as a Medi-Cal member, the provider has no authority to access the individual's confidential eligibility information.

Verifying Member Eligibility

The Point of Service (POS) network is set up to verify eligibility and perform Share of Cost. The POS network may be accessed through the Internet or through the Automated Eligibility Verification System (AEVS).

Internet

Providers can verify member eligibility and clear Share of Cost liability on the Medi-Cal website here. An Eligibility Verification Confirmation (EVC) number on the Internet eligibility response verifies that an inquiry was received, and eligibility information was transmitted. This response should be printed and kept in the recipient's file.

Providers who check eligibility via AEVS over the phone do not automatically have access to check eligibility through Medi-Cal's website. Providers who wish to use the Medi-Cal website application are required to have a Medi-Cal Point of Service (POS) Network/Internet Agreement on file with Medi-Cal Dental.

Questions regarding this form or the Medi-Cal website should be directed to EDS POS/ Internet Help Desk at (800) 427-1295.

Automated Eligibility Verification System (AEVS)

An Eligibility Verification Confirmation (EVC) number verifies that an inquiry was received, and eligibility information was transmitted. (Please click here for information about using telephone AEVS.)

The table below show the alphabetic code listings codes for entering alphabetic data:

Letter	2 Digit Code	Letter	2 Digit Code
A	*21	N	*62
B	*22	0	*63
c	*23	p	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	s	*73
G	*41	T	*81
H	*42	u	*82
I	*43	v	*83
J	*51	w	*91
K	*52	x	*92
L	*53	y	*93
M	*61	z	*12

Share of Cost (SOC)

If the Medi-Cal eligibility verification system indicates a member has a Share of Cost (SOC), the SOC must be met before a member is eligible for Medi-Cal benefits. Refer to the applicable transaction manual for directions on applying SOC.

SOC was developed by the Department to ensure an individual or family meets a predetermined financial obligation for medical and dental services before receiving Medi-Cal benefits. Prior authorization requirements are not waived for SOC members. The SOC obligation is incurred each month and, consequently, the amount of obligation may vary from month to month. The dollar amount to be applied to any health care cost incurred during that month is computed in order to meet the SOC. Health care costs could be dental, medical, pharmaceutical, hospital, etc. Members may use non-Medi-Cal covered services in meeting the monthly SOC obligation.

Providers can determine a member’s SOC when verifying the member’s eligibility through AEVS or by referring to the member’s SOC Case Summary letter. AEVS will report if a member has an unmet SOC before providing an EVC. Providers may collect payment on the date that services are rendered, or they may allow a member to pay for the services later or through an installment arrangement. SOC obligations are between the member and the provider and should be in writing and signed by both parties.

The Medi-Cal SOC obligation can apply to an individual or family. Family members who are not eligible for Medi-Cal may be included in the member's SOC. The health care

costs for these ineligible family members can be used to meet the SOC obligation for family members who are eligible. Ineligible family members who can do this are identified by an “IE” or “00” aid code on the member’s SOC letter.

Natural or adoptive parents (coded as Responsible Relative (RR) on their child’s SOC form) may choose to apply their medical expenses towards their own SOC or towards their child’s SOC. In this instance, parents’ expenses can be listed fully towards their own SOC or applied partially towards their SOC and any of their children’s SOC. However, the total amount reported for a single medical expense cannot be more than the original bill.

An example of this situation would be a family that consists of a stepfather, his wife and his wife’s separate child. The wife and her husband are listed as eligible recipients on the same SOC letter with a $100 SOC. The wife’s separate child is listed on a different SOC letter with a $125 SOC. The wife is also listed on her child’s SOC letter with an “RR” code in the aid code field.

The wife has expenses that total $75 and that have not been billed to Medi- Cal. She may do one of the following:

1. Apply the entire $75 to her own $100 SOC.
2. Apply the entire $75 to her own child’s $125 SOC.
3. Apply any amount less than $75 to her SOC and the balance of the $75 to her child’s SOC. The total amount reported cannot exceed the original $75.

Providers should submit a SOC clearance transaction immediately upon receiving payment from the member. The SOC clearance transaction can be performed by entering the amount through AEVS. Once this amount has been entered, eligibility can be established for that month for the family members eligible for Medi-Cal. If the member’s SOC obligation has been met, providers are entitled to bill Medi-Cal Dental for those services that have been partially paid for by the member and all other services not paid for by the member. However, total payments from the member and Medi-Cal Dental will not exceed the Schedule of Maximum Allowances (SMA).

Interactive Voice Response (IVR) System

The Medi-Cal Dental Interactive Voice Response (IVR) System is a touch-tone only system providing general program information. General program information is available 24 hours a day, seven days a week on the IVR system. To by-pass the entire response, press the required key.

With the IVR system, providers can call the Telephone Service Center at (800) 423-0507 and select IVR option 2 for interpreter services to access language interpreters in approximately 250 languages. Under Medi-Cal Dental, language interpreter services are available to Medi-Cal members at no cost. Please note that language interpreter services cannot be scheduled in advance. Members who need

language interpretation assistance at a dental appointment may also request an interpreter through the member IVRs main menu by selecting one of the languages noted and then choosing option 1 when prompted. The member IVR can be accessed by calling the Telephone Service Center toll-free at (800) 322-6384.

Patient history, claim/TAR status and financial information can be accessed using the IVR system, seven days a week, 2:00 a.m. to 12:00 midnight, with little or no wait time.

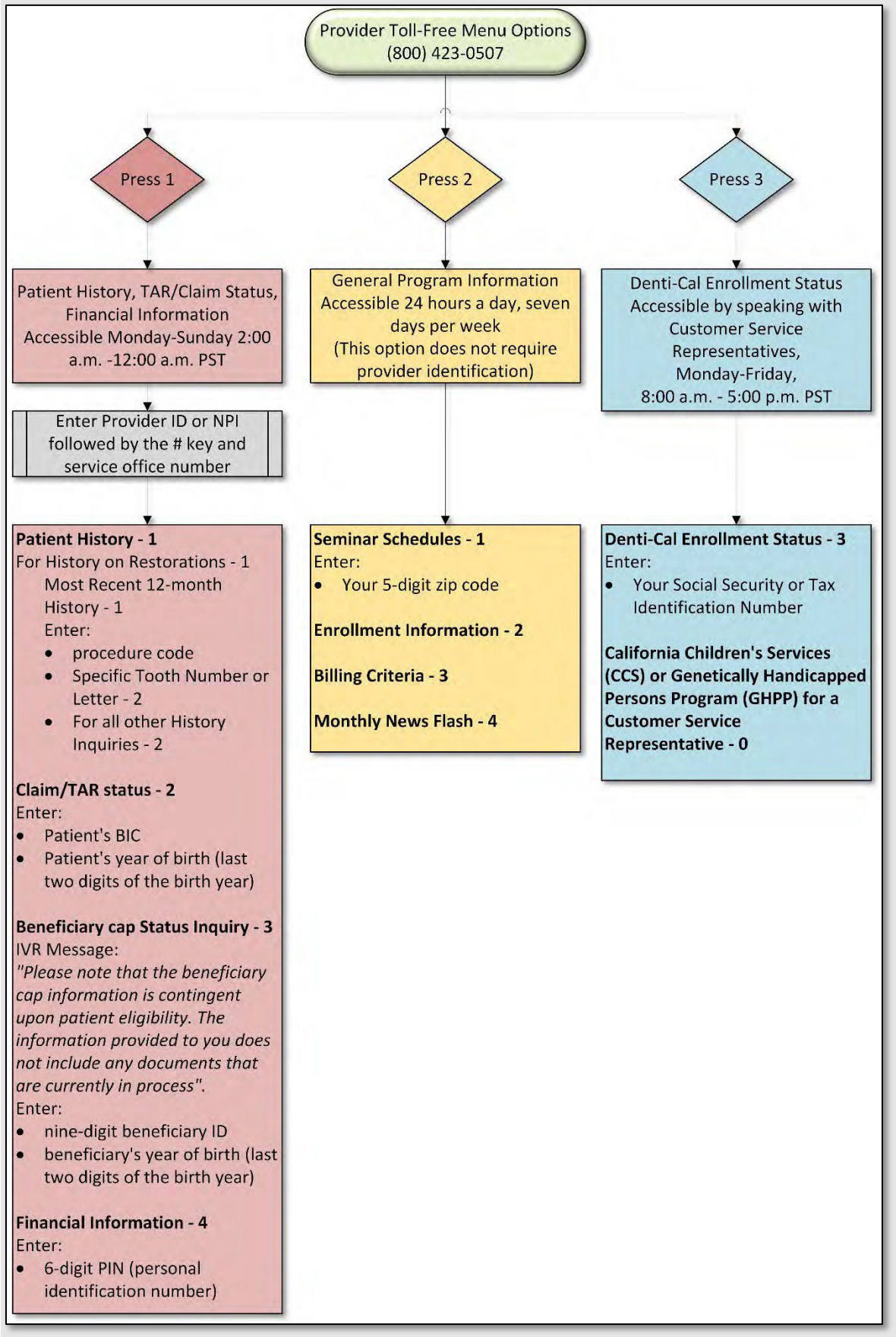
Note: Member aid code status is only accessible by speaking with a Customer Service Representative by calling (800) 322-6384, Monday through Friday, between 8:00 a.m. and 5:00 p.m. (the best time is between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m.).

To access the IVR, enter the star key (*) followed by the provider's NPI. The IVR allows providers to check history and billing criteria. Patient history information can be obtained by entering the NPI followed by the pound (#) key and entering the current Medi-Cal Dental service office number. Then press "1" from the main menu and enter the provider identification (ID) number. If the provider ID number starts with "B," press the star (*) key, then the number "2," and the number "2" again, followed by the five numbers of your assigned provider number. If the provider number starts with "G" press the star (*) key, then the number "4," followed by the number "1," followed by the five numbers of your assigned provider number. Begin entering patient information by pressing "1" again, then follow the prompts. This option in the IVR gives history on radiographs, prophylaxes, dentures, and many other procedures.

Providers may verify the available balance of a member's dental soft cap. For information regarding member soft cap status, press 1, then press 3, and follow the prompts. Providers are reminded that member soft cap information is contingent upon patient eligibility and does not include any documents currently in process.

Providers may request by FAX: The Schedule of Maximum Allowances (SMA) and the clinical screening dentist application. In addition to details regarding basic and advanced seminars, providers may now get information on orthodontic seminars and workshops.

Note: To check member eligibility, continue to use AEVS: (800) 456-2387.


Provider Toll-Free Menu Options
(800) 423-0507
Press 1
Press 2
Press 3
Patient History, TAR/Claim Status, Financial Information Accessible Monday-Sunday 2:00 a.m. -12:00 a.m. PST
General Program Information Accessible 24 hours a day, seven days per week (This option does not require provider identification)
Denti-Cal Enrollment Status Accessible by speaking with Customer Service Representatives, Monday-Friday, 8:00 a.m. - 5:00 p.m. PST
Enter Provider ID or NPI followed by the # key and service office number
Patient History - 1
For History on Restorations - 1
Most Recent 12-month History - 1
Enter:
procedure code
Specific Tooth Number or Letter - 2
For all other History Inquiries - 2
Claim/TAR status - 2
Enter:
Patient's BIC
Patient's year of birth (last two digits of the birth year)
Beneficiary cap Status Inquiry - 3
IVR Message:
"Please note that the beneficiary cap information is contingent upon patient eligibility. The information provided to you does not include any documents that are currently in process".
Enter:
nine-digit beneficiary ID
beneficiary's year of birth (last two digits of the birth year)
Financial Information - 4
Enter:
6-digit PIN (personal identification number)
Seminar Schedules - 1
Enter:
Your 5-digit zip code
Enrollment Information - 2
Billing Criteria - 3
Monthly News Flash - 4
Denti-Cal Enrollment Status - 3
Enter:
Your Social Security or Tax Identification Number
California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) for a Customer Service Representative - 0

Member Coverage

Treating Members

To improve efficiency and timely access to care, maintain quality of care for a patient, a treating dental provider shall, when applicable, feasible, and consistent with the standard of care, minimize the number of dental visits. Each patient should receive an individualized treatment plan that is safe, effective, patient centered and equitable. Documentation must justify deviation from the treatment plan.

Safety Net Clinics (Federally Qualified Health Centers, Rural Health Clinics, Indian Health Clinics) may render any dental service in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental Manual of Criteria, and determined to be medically necessary pursuant to California Welfare & Institutions Code §14059.5. Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient centered, timely, and efficient manner.

For dental services, documentation should be consistent with the standards set forth in the Manual of Criteria for Medi-Cal Authorization (Dental Services) of the Medi-Cal Dental Provider Handbook and all state laws. Safety Net Clinics may render Medi-Cal Dental covered services and non-covered Medi-Cal Dental services in the same visit as long as it complies with the above guidance.

ACA's Non-Discrimination Policy Applies to Medi-Cal

Section 1557 of Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities. In effect since 2010, Section 1557 builds on long-standing federal civil rights laws: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

The Health and Human Services (HHS) Office for Civil Rights issued its final rule implementing Section 1557 at Title 45 Code of Federal Regulations Part 92. The rule applies to any health program or activity, any part of which receives federal financial assistance, an entity established under Title I of the ACA that administers a health program or activity, and HHS. In addition to other requirements, Title 45 CFR Part 92.201, requires:

- *Language assistance services requirements*
  - Language assistance services required under paragraph (a) of Part 92.201 must be accurate, timely and provided free of charge, and protect the privacy and independence of the individual with limited English proficiency

- *Specific requirements for interpreter and translation services* Subject to paragraph (a) of Part 92.201:
  - A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency
  - A covered entity shall use a qualified translator when translating written content in paper or electronic form

For more information about the application and requirements of the final rule implementing Section 1557, providers should contact their representative professional organizations. They might also visit the Section 1557 of the Patient Protection and Affordable Care Act page of the HHS website to find sample materials and other resources.

On June 12, 2020, HHS Office of Civil Rights (OCR) announced a final rule revising its Section 1557 regulations, effective August 18, 2020. The rule eliminates preexisting federal rules protecting individuals from discrimination based on categories like gender identity and sexual orientation. In addition, the final rule eliminates federal requirements that Medicaid programs include taglines in significant communications that inform individuals with Limited English Proficiency about the availability of language assistance services. The full rule can be found in the Federal Register here.

Regardless of the change in federal regulations, under California law (California Government Code § 11135), no person may—on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, or sexual orientation—be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, administered or funded by the State. This includes, but is not limited to, the Medi-Cal program. In addition, California law (California Welfare and Institutions Code §§ 14029.91, 14029.92) requires DHCS, as well as managed care plans providing covered benefits to DHCS members, to provide notice of the availability of free language assistance services in English and in the top 15 languages spoken by limited English-proficient individuals in California.

Restoration of Adult Dental Services

Adult dental services were limited between July 1, 2009 and December 31, 2017.

Effective January 1, 2018, adult dental services were fully restored. Restored benefits include, for example, posterior root canal therapy, periodontal services, partial dentures, denture adjustments/repairs, and relines. The complete list of dental benefits is available in the dental Manual of Criteria posted on the Medi-Cal Dental website. Refer to the Benefits Quick Reference Guide on page 4-11.

There are no changes to the current scope of benefits for the following adult members:
Pregnancy-related services

- Emergency services
- Services provided to residents of an Intermediate Care Facility/Skilled Nursing Facility
- Services provided to Consumers of the Department of Developmental Services (DDS)
- Services provided to Genetically Handicapped Person's Program (GHPP)

In addition, Program is adding Periodontal Maintenance (D4910) as a new benefit to:

- All members with Full Scope Aid Code
- Pregnancy-related services
- Services provided to Consumers of the Department of Developmental Services (DDS)
- Services provided to Genetically Handicapped Person's Program (GHPP)

For dates of service **prior** to January 1, 2018, members 21 years of age and older are restricted to the benefits outlined in Table 1: Federally Required Adult Dental Services (FRADS) and Table 3: Restored Adult Dental Services (RADS).

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes are reimbursable for members 21 years of age and older. Note: Procedure codes marked with an asterisk (*) are only payable when the procedure is appropriately rendered in conjunction with another FRADS or pregnancy related procedure.

D0250*, D0310*, D0320*, D0322*, D0502, D0999, D2910, D2920, D2940, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5953, D5954, D5955, D5958, D5959, D5960, D5982, D5983, D5984, D5985, D5986, D5987, D5988, D5999, D6092, D6093, D6100, D6930, D6999, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7540, D7451, D7460, D7461, D7465, D7490, D7510, D7511, D7520, D7521, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, 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, D7910, D7911, D7912, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7955, D7971, D7979, D7980, D7981, D7982, D7983, D7990, D7991, D7995, D7997, D7999, D9110, D9210, D9222, D9223, D9230, D9239, D9243, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9930, D9999.

Table 3: Restored Adult Dental Services (RADS)Effective May 1, 2014, some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82).

D0150, D0210, D0220, D0230, D0270, D0272, D0274, D0330, D0350, D1110, D1206, D1208, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932, D2933, D2952, D2954, D3310, D3346, D5110, D5120, D5130, D5140, D5410, D5411, D5511, D5512, D5520, D5611, D5612, D5730, D5731, D5750, D5751, D5850, D5851, D5863, D5865.

Medi-Cal Benefits Expansion for Adults 50 Years of Age or Older

On May 1, 2022, California expanded full-scope Medi-Cal coverage to adults 50 years of age or older, regardless of immigration status. All other Medi-Cal eligibility rules, including income limits, will still apply. Under this expansion, eligible adults in restricted scope Medi-Cal (Emergency Medi-Cal) are eligible for full-scope Medi-Cal benefits. This includes free and low-cost dental services. This coverage expansion includes approximately 185,000 individuals 50 years of age or older who are currently enrolled in restricted scope Medi-Cal.

Benefits Quick Reference Guide

Below is a benefits quick reference guide for providers effective January 1, 2018. The benefits are based on aid codes and where a member resides. For a complete listing of procedures and their guidelines, please refer to the Manual of Criteria found in the Handbook. Additional information is on the Medi-Cal Dental website.

	✓ Benefit ✗ Not a benefit			
Procedure	**Full Scope**	**Restricted Scope**	**Pregnancy Related**	**Residing in a Facility (SNF/ICF)**
Oral Evaluation (Under age 3)*	✓	✗	✗	✓
Initial Exam (Age 3 and above)	✓	✗	✓	✓
Periodic Exam (Age 3 and above)	✓	✗	✓	✓
Prophylaxis	✓	✗	✓	✓
Fluoride	✓	✗	✓	✓
Restorative Services – Amalgams/Composites/ Pre-fabricated Crowns	✓	✗	✓	✓

Laboratory Processed Crowns**	✓	✗	✓	✓
Scaling and Root Planing***	✓	✗	✓	✓
Full Mouth Debridement	✗	✗	✗	✓
Periodontal Maintenance	✓	✗	✓	✓
Anterior Root Canals	✓	✗	✓	✓
Posterior Root Canals	✓	✗	✓	✓
Partial Dentures	✓	✗	✓	✓
Full Dentures	✓	✗	✓	✓
Extractions/Oral and Maxillofacial Surgery	✓	✓	✓	✓
Emergency Services	✓	✓	✓	✓

Exceptions:

*	ONLY a benefit underage 3.
**	Not a benefit underage 13.
***	Not a benefit under age 13. Allowable under special circumstances.

California Advancing and Innovating Medi-Cal (CalAIM) Oral Health Initiatives

On January 1, 2022, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, comprised of three oral health components, will be in effect. CalAIM is a multi- year initiative that aims to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

The three oral health components of CalAIM are built on the successful outcomes of the Dental Transformation Initiative (DTI) and each CalAIM oral health initiative is described below.

Pay-for-Performance (P4P): Preventive Services and Continuity of Care

P4P is comprised of two initiatives: Preventive Services and Continuity of Care. Select procedure codes eligible for CalAIM P4P payments can be found on the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances page.

The Preventive Services P4P offers a performance payment for each paid preventive oral care service billed by a service office location in order to increase statewide utilization of preventive services. Preventive P4P will be:

- Available to all enrolled Medi-Cal dental providers.
- Paid at an additional 75 percent of the Schedule of Maximum Allowances (SMA) for select preventive procedures. For details, please refer to the CalAIM P4P Preventive Services table in Provider Bulletin Volume 38, Number 01.
- Processed and paid in accordance with the January 2022 draft Manual of Criteria (MOC) and SMA. Visit the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances page to access the January 2022 draft MOC and SMA.
- Included in the weekly check write for all qualified paid preventive services

The Continuity of Care P4P offers a flat rate performance payment paid once a calendar year to service office locations that maintain dental continuity of care and establish a dental home for each patient by performing at least a yearly dental exam/evaluation for two or more years in a row. Continuity of Care P4P will be:

- Available to all service office locations who meet the requirements.
- Begin payments in calendar year (CY) 2022 for returning patients seen in CY 2021. 2021 is the “baseline” year for this P4P.
- Paid at the flat rate of $55 once per year in addition to the SMA for the specified procedures codes below. For details, please refer to the CalAIM P4P Continuity of Care table in Provider Bulletin Volume 38, Number 01.
- Processed and paid in accordance with the January 2022 draft MOC and SMA. Visit the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances page to access the January 2022 draft MOC and SMA.
- Included in the weekly check write for all qualified paid continuity of care services.

New Benefits

Caries Risk Assessment (CRA) bundle and Silver Diamine Fluoride (SDF) are two new benefits added to the Medi-Cal Dental in alignment with national dental care standards.

CRA Bundle

- Dental providers **must** take the Treating Young Kids Everyday (TYKE) training, complete the related attestation form, and provide proof of TYKE course completion to receive payment for the CRA bundle.
- Dental providers who have record of completing the TYKE training for DTI Domain 2 pilot project are **not required** to retake the TYKE training for CalAIM.

- CRA bundle include a CRA exam (D0601, D0602, D0603) and nutritional counseling (D1310) based on the risk level associated for Medi-Cal members **ages 0-6 only**. All CRA bundle services claims will be processed and paid in accordance with the January 2022 draft MOC and SMA. Visit the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances page to access the January 2022 draft MOC and SMA.
- Additional services, such as cleaning, fluoride, and exam (D0120, D1120, D1206, and D1208) can be rendered at the allowed increased frequencies based on the risk level.
- The CRA bundle services may be billed by:
    - Dentists, and
    - Registered Dental Hygienists in Alternate Practice (RDHAPs).

CRA Bundle Fee Schedule

	Caries Risk Assessment ($15.00)	Nutritional Counseling ($46.00)	Frequency	Bundle Fee
Low Risk	D0601	D1310	6 months	$61.00
Moderate Risk	D0602	D1310	4 months	$61.00
High Risk	D0603	D1310	3 months	$61.00

Silver Diamine Fluoride

- SDF claims will be processed and paid in accordance with the January 2022 draft MOC and SMA. Visit the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances page to access the January 2022 draft MOC and SMA.
- Criteria for SDF **D1354**: *Interim Caries Arresting Medicament Application-Per Tooth* is as follows:
    1. Radiographs and photographs for payment – For patients under the age of 7 submit a current intraoral photograph demonstrating the medical necessity. For patients age 7 or older, in addition to a current intraoral photograph, providers must submit a current, diagnostic periapical radiograph and must document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal.
    2. Requires a tooth code.
    3. A benefit:
        a. for patients under the age of 7.
        b. for patients aged 7 or older when documentation shows underlying conditions such that nonrestorative caries treatment may be optimal.
        c. once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth.

4. Not a benefit:
    a. when the prognosis of the tooth is questionable due to no restorability.
    b. when a tooth is near exfoliation.

- D1354 is not a benefit when the prognosis of the tooth is questionable due to no restorability or when a tooth is near exfoliation.

As a result of these initiatives, four new Adjudication Reason Codes (ARCs) – ARC 266P, ARC 440, ARC 506, and ARC 507 – were added and two ARCs – ARC 002A and ARC 320C – were modified. The descriptions for these ARCs can be found in "Section 7 – Codes" of this Handbook.

Proposition 56: Tobacco Tax Funds Supplemental Payments

The California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, was approved by voters at the November 8, 2016, statewide general election. Proposition 56 increased taxes imposed on cigarettes and tobacco products and allocated a specified percentage of those revenues to the Department of Health Care Services (DHCS) to increase funding for existing health care programs under the Medi-Cal program.

Assembly Bill 120 (Statutes of 2017, Chapter 22, §3, Item 4260-101-3305) amended the Budget Act of 2017 to appropriate Proposition 56 funds for specified DHCS health care expenditures during the 2017-18 state fiscal year. Prop 56 was reauthorized pursuant to Senate Bill 856 (Chapter 30, §3, Item 4260-101-3305, Statutes of 2018), and DHCS received additional funds to extend the Prop 56 supplemental payments through June 30, 2019, and expand supplemental payments to additional procedure codes during the 2018-19 state fiscal year. Pursuant to Assembly Bill 74 (Chapter 23, §3, Item 4260-101-3305, Statutes of 2019), Prop 56 supplemental payments were then extended through Calendar Year (CY) December 31, 2021.

Effective January 1, 2022, pursuant to the 2021 Budget Act, the Department of Health Care Services (DHCS) is authorized to continue Prop 56 supplemental payments for specified dental codes. The supplemental payment categories for dental services include visits and diagnostics, preventative, restorative, endodontic, periodontics, prosthetic, oral and maxillofacial surgery, orthodontics, and adjunctive services.

Proposition 56 funds will be utilized for supplemental payments for dental services under the Medi-Cal program for providers who bill under the Dental Fiscal Intermediary or Dental Managed Care plans. In accordance with Assembly Bill 120, DHCS will provide supplemental payments in addition to the current dental Schedule of Maximum Allowances (SMA) for specific procedures, targeted to increase provider participation. The extended supplemental payments are retroactive to July 1, 2018 and issued for the specified codes for dates of service during the period of July 1, 2018 until further notice. DHCS is not changing the SMA for these procedures, but rather providing a

supplemental payment in addition to the existing SMA. For more information about Prop 56, please visit the DHCS Proposition 56 Supplemental Dental Payments webpage.

As a result of the Proposition 56 expansion, Adjudication Reason Codes (ARCs) 505, 505A, and 403B were updated and are available to participating Medi-Cal dental providers as described in "Section 7 – Codes" of this Handbook.

$1,800 Limit per Calendar Year for Member Dental Services, with Exceptions

The fiscal year (FY) 2005-2006 Budget Act required the Department to employ changes in covered benefits as set forth in Assembly Bill 131 (Chapter 80, Statutes of 2005). Assembly Bill 131 amends Section 14080 of the Welfare and Institutions Code by limiting non-exempt dental services for members 21 years of age or older to $1,800 per member for each calendar year. Providers should refer to the Welfare and Institutions (W & I) Code § 14080 and the 2009, 2013, and 2017 State Plan Amendments for the latest information.

However, the annual $1,800 per member dental soft cap does not apply to procedures the Department deems medically necessary.

Medi-Cal dental providers do not need to take any action as a result of this change and are not responsible for checking a Medi-Cal member's dental soft cap prior to rendering medically necessary services. All previously authorized services on Treatment Authorization Requests (TARs) or medically necessary procedures billed on claims will not be subject to the $1,800 member dental soft cap as long as the procedures have met the criteria requirements outlined in the Manual of Criteria (MOC).

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

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

Pregnancy-Related Services

Pregnancy-related services are services required to assure the health of the pregnant woman and the fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, family planning services and services for other conditions that might complicate the pregnancy. Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Effective April 1, 2022, Medi-Cal members will be covered for all medically necessary services during pregnancy and 12 months past the end of their pregnancy as part of the American

Rescue Act Plan (ARPA). This expansion provides an additional 10-months postpartum coverage at the end of a member's 60-day postpartum period for a total of 12 months. Eligibility will be granted to any individual in an aid code where postpartum services are a covered benefit.

Pregnant members, regardless of aid code, and/or scope of benefits are eligible to receive all dental procedures listed in the Medi-Cal Dental Manual of Criteria (MOC) that are covered by the Medi-Cal program so long as all MOC procedure requirements and criteria are met.

For dental services for a pregnant or postpartum woman who does not have full scope Medi-Cal, write "pregnant" or "postpartum" in the Comments section of claim. If you receive a denial (Adjudication Reason Code 503A or 503B) for a covered service for a pregnant/postpartum member, you should submit a Claim Inquiry Form (CIF) indicating "PREGNANT" or "POSTPARTUM" in the "REMARKS" field plus any additional documentation and radiographs pertinent to the procedure for reconsideration.

Radiograph Requirements for Pregnant and Postpartum Members

For all procedures that require radiographs/prior authorization, no payment will be made if the radiographs are not submitted. "Patient refused x-rays" will not be acceptable documentation for non-submission of radiographs. Additional information regarding dental care during pregnancy can be found at the CDA Foundation website here.

Long-Term Care

Members will be excluded from the dental soft cap if they have Long Term Care (LTC) aid codes or reside in either Place of Service 4/SNF (Skilled Nursing Facility) or Place of Service 5/ICF (Intermediate Care Facility). Exempt long term aid codes include 13, 23, 53, and 63 (for more information on Aid Codes, refer to the end of this section). Descriptions of these and other aid codes are found in the following pages of this section.

All other aid codes and procedure codes can be subject to the $1,800 soft cap.

Patients With Special Healthcare Needs

Patients with special healthcare needs are defined as those patients who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform an examination.

Patients may be classified as patients with special healthcare needs when a provider has adequately documented the specific condition and the reasons why an examination and treatment cannot be performed without general or intravenous sedation.

Prior authorization is not required for treatment (with the exception of fixed partial dentures, removable prosthetics and implants) in order to minimize the risks associated with sedation.

When treatment is performed without prior authorization (on a procedure that normally would require prior authorization), requests for payment must be accompanied by documentation to adequately demonstrate the medical necessity. Refer to the individual procedures for specific requirements and limitations in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

In cases not requiring general anesthesia or procedural sedation photographs may be substituted for radiographs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or Claim.

Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to physical limitation and/or an oral condition that prevents daily oral hygiene.

Dental Case Management is available for those patients who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers. Case management services are intended for members with significant medical, physical, and/or behavioral diagnosis. Referrals for case management services are initiated by the member's medical provider, dental provider, case worker or healthcare professional and are based on a current, comprehensive evaluation and treatment plan.

https://dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/Dental_Case_Management_Program/

American Sign Language (ASL) Translation Services

American Sign Language (ASL) translation services are available to Medi-Cal dental members. To request an ASL translator be present at the time of the appointment, either the provider or the member must contact Medi-Cal Dental and provide the following information:

- Date of dental appointment
- Start and end time of appointment
- Appointment type (dental, surgical, consult, etc.)
- Name of person needing ASL services
- Office address
- Office contact
- Office phone number

To schedule an ASL translator, providers can call the Telephone Service Center provider line
at (800) 423-0507. Members can call the Telephone Service Center member line at (800) 322-6384.

Treating Members That Reside in Other Counties

Enrolled Medi-Cal dental providers can treat any eligible member in Medi-Cal Dental no matter where the member resides. Medi-Cal dental providers can provide services to eligible members that reside in other counties in addition to the county the provider is located. To check
Medi-Cal eligibility of a member, please call the Automated Eligibility Verification System (AEVS) at (800) 456-2387.

Non-Medical Transportation (NMT)

Pursuant to Welfare and Institutions Code (W&I Code) Section 14132 (ad) (1), effective for dates of service on or after July 1, 2018, non-medical transportation (NMT) is a covered
Medi-Cal benefit, subject to utilization controls and permissible time and distance standards, for a member to obtain covered Medi-Cal services. The NMT benefit is eligible full-scope Medi-Cal fee-for-service members and pregnant women during pregnancy and for 12 months postpartum, including any remaining days in the month in which the last postpartum day falls. NMT includes transporting recipients to and from Medi-Cal covered medical, mental health, substance abuse or dental services. Members enrolled in a Medi-Cal managed care health plan must request NMT services through their Member Services.

W&I Code 14132 (ad)(2)(A)(i) defines NMT as including, at minimum, round trip transportation for a recipient to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance. NMT services are a benefit only from an enrolled NMT Provider.

NMT does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated recipients by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations, since these would be covered as non-emergency medical transportation (NEMT) services. For more details and information on eligibility for NMT/NEMT services, refer to the guide
located here.

Please refer to the Member Handbook on the Medi-Cal Dental website to help your patients find information about their qualifying appointment(s).

Community Health Worker (CHW) Preventive Services

Medi-Cal dental claims may be sent for community health worker (CHW) services, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a licensed healthcare provider within their scope of practice under state law.

CHW services must address issues related to oral health.

Community health worker (CHW) services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health.

Community health workers may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

The **plan of care** is a written document that is developed by one or more licensed providers to describe the supports and services a CHW will provide to address ongoing needs for a member. A CHW may assist in developing a plan of care with the licensed provider.

The **supervising provider** is an enrolled Medi-Cal provider who submits dental claims for services provided by CHWs. The supervising provider ensures a CHW meets the qualifications listed in this document, and directly or indirectly oversees a CHW and their services delivered to Medi-Cal members. It is the supervising provider's responsibility to maintain records of the CHW's qualifications and these documents must be made available upon request by the Department of Healthcare Services.

Covered CHW Dental Services

- **Oral health education** to promote the member's oral health or address barriers to dental health care, including providing information consistent with established or recognized oral health care standards.
- **Oral health navigation** to provide information, training, referrals, or support to assist members to:
- Access health care, understand the health care system, or engage in their own oral health care
- Connect to community resources necessary to promote a member's oral health; address health care barriers, including connecting to dental translation/interpretation or transportation services; or address health-related social needs.
- Serve as a cultural liaison or assist a licensed health care provider to create a plan of care, as part of a health care team
- Outreach and resource coordination to encourage and facilitate the use of appropriate preventive services
- **Screening and assessment** that does not require a license and that assists a member to connect to appropriate services to improve their oral health

Note: These services may also be rendered by a licensed provider within their scope of practice.

Services may be provided to a parent or legal guardian of a Medi-Cal member under the age of 21 for the direct benefit of the member, in accordance with a recommendation from a licensed provider. A service for the direct benefit of the member must be billed under the member's Medi-Cal ID. If the parent or legal guardian of the member is not enrolled in Medi-Cal, the member must be present during the session.

Billing Codes
The following CDT code may be used for all services listed above by the supervising provider when submitting claims:

- D9994 (DENTAL CASE MANAGEMENT – PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY)

Maximum frequency is four units (two hours) daily per member, for any provider. Additional units per day may be provided with an approved Treatment Authorization Request (TAR) for medical necessity. TARs may be submitted after the service was provided. A written plan of care is required for continued CHW services after 12 units of care per member in a single year, with the exception of services provided in the Emergency Department. Please see DHCS CHW Provider Manual for further information.

CHW Billing Codes

CDT Code	Description	Length	No. of Patients	Rate Per Member	Maximum Reimbursement without a TAR[1]
D9994	Oral health education and training for patient self-management by a qualified, non-licensed health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	30 minutes (1 unit)	1	$26.66	1 member: $106.64
D9994	Oral health education and training for patient self-management by a qualified, non-licensed health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	30 minutes (1 unit)	2–4	$12.66	2 members: $101.28 3 members: $151.92 4 members: $202.56
D9994	Oral health education and training for patient self-management by a qualified, non-licensed health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	30 minutes (1 unit)	5–8	$9.46	5 members: $189.20 6 members: $227.04 7 members: $264.88 8 members: $302.72

Non-covered Services

- Clinical case management/care management that requires a license
- Childcare
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Delivery of medication, medical equipment, or medical supply
- Personal Care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a member
- Socialization
- Transporting members
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license

Although CHWs may provide CHW services to members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

Teledentistry

CHW services rendered under D9994 should not exceed 90 minutes (30 units) when performed via teledentistry. Supervising providers should refer to the *Teledentistry* section in Section 4 of the Medi-Cal Dental Provider Manual for guidance regarding providing services via teledentistry.

Documentation Requirements

CHW services billable to Medi-Cal require a written recommendation by a dentist or hygienist within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the member's managed care plan.

CHWs are required to document the number of members seen, dates, and time of services provided to members on each submitted claim form. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.

Written documentation for payment shall include the name of the CHW that provided the training, the number of Members present at the training, and the time of the training session

(i.e. 12:30PM - 1:00PM). Additional documentation must be present in the Member's chart and accurately reflect the duration of time and the nature of services rendered.

Plan of care

Providers are encouraged to develop a written plan of care when a need for multiple or ongoing CHW services is identified. A written plan of care is required for continued CHW services after 12 units of care per member in a single year, with the exception of services provided in the Emergency Department. The written plan of care must be developed by one or more licensed providers. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services. CHWs may participate on the team that develops the plan of care. The plan of care may not exceed a period of one year. The plan must meet the following conditions:

- Specifies the condition that the service is being ordered for and be relevant to the condition
- Includes a list of other health care professionals providing treatment for the condition or barrier
- Contains written objectives that specifically address the recipient's condition or barrier affecting their health
- Lists the specific services required for meeting the written objectives
- Includes the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the care plan's objectives

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

Eligibility Criteria

CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma impacting the member's oral health, who are at risk for a chronic health condition or environmental health exposure impacting the member's oral health, who face barriers meeting their oral health or oral health-related social needs, and/or who would benefit from preventive oral health services. The recommending provider shall determine whether a member meets the medical necessity criteria for CHW services based on the presence of one or more of the following that could impact the member's oral health:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed, that could impact the member's oral health.

- Medical indicators of chronic disease that are impacting or could impact the member's oral health
- Positive Adverse Childhood Events (ACEs) screening affecting oral health
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse affecting oral health
- Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity, that could have an impact on the member's oral health
- One or more visits to a hospital emergency department within the previous six months for a non-traumatic oral health visit
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization, that could impact the member's oral health
- One or more stays at a detox facility within the previous year affecting oral health
- Two or more missed dental appointments within the previous six months
- Member expressed need for support in oral health system navigation or resource coordination services
- Need for recommended preventive oral health services

Place of Service
There are no Place of Service restrictions for CHW services.

Claim Submission

Claims for CHW services must be submitted by the Medi-Cal dental enrolled supervising provider.

Supervision Requirements
CHWs must be supervised by a licensed Medi-Cal dentist or hygienist. The supervising provider does not need to be the same entity as the provider who made the written recommendation for CHW services. Supervising providers do not need to be physically present at the location when CHWs provide services to members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the supervising provider. However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements as described herein.

CHW Minimum Qualifications
CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served. This may include, but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

CHWs with lived experience does not restrict CHWs to providing services only to members with whom they share a direct lived experience with. CHWs may serve a diverse range of individuals and communities within their role, as long as CHWs are equipped with the necessary skills, knowledge, and training to address the oral health needs of those populations. Supervising providers are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving, but this should not limit their ability to work with broader groups beyond their own personal lived experiences.

CHWs must demonstrate minimum qualifications through one of the following pathways, as determined by the supervising provider:

- **Certificate Pathway.** CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
    1. **CHW Certificate:** A certificate of completion, including but not limited to any certificate issued by the State of California or a State designee, of a curricula that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health, as determined by the supervising provider. Certificate programs shall also include field experience as a requirement.

       A CHW Certificate allows a CHW to provide all covered CHW services described in this document, including violence prevention services.
    2. **Violence Prevention Certificate:** For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.

       A Violence Prevention Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services shall demonstrate qualification through either the Work Experience Pathway or by completion of a CHW Certificate.
- **Work Experience Pathway:** An individual who has 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined by the supervising provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Medi-Cal member.

All CHWs must complete a minimum of 6 hours of additional training annually. The supervising provider shall maintain evidence of the CHWs completing continuing education requirements in case of audit.
Supervising providers may provide and/or require additional training, as identified by the supervising provider.

Teledentistry

The Department of Health Care Services has opted to permit the use of teledentistry as an alternative modality for the provision of select dental services. Therefore, enrolled Medi-Cal dental billing providers may submit documents for services rendered utilizing teledentistry.

The goal of teledentistry is to allow Medi-Cal Dental providers to practice "teledentistry" as another modality of treating Medi-Cal Dental members. This can be done through Synchronous Teledentistry, which is a real time encounter or through Asynchronous Teledentistry, which is defined to mean the transmission of medical/dental information to be reviewed at a later time by a licensed dental provider at a distant site.

DHCS has expanded its teledentistry policy to allow Medi-Cal dental Fee-for-Service (FFS) and Dental Managed Care (DMC) providers the ability to establish new patient relationships through an asynchronous store and forward modality, consistent with Federally Qualified Health Center/Rural health Clinic (FQHC/RHC) providers. Additionally, DHCS enables providers the flexibility to use teledentistry as a modality to render appropriate services based upon service categories when in compliance with all of the following requirements:

- The procedure is in the diagnostic (D0100-D0999) or preventive (D1000-D1999) service categories and could appropriately be rendered through Teledentistry.
- Teledentistry is NOT allowable for all other service categories and CDT codes (D2000- D9999) except D9995 and D9996, which are the teledentistry modality codes; and D9430 and D9994 which can only be rendered through Synchronous Teledentistry (D9995).

- Dental providers billing for services delivered via teledentistry must be enrolled as Medi- Cal dental providers. The dental provider rendering Medi-Cal covered benefits or services via a teledentistry modality must be licensed in California, enrolled as a Medi-Cal Dental rendering provider, operate within their allowable scope of practice, and meet applicable standards of care.
- All services rendered through teledentistry must be in compliance with the Manual of Criteria (MOC), including documentation requirements to substantiate the corresponding technical and professional components of billed CDT codes.
- A patient who receives teledentistry services under these provisions shall also have the ability to receive in-person services from the dentist or dental practice or assistance in arranging a referral for in-person services.
- Procedure does not require in-person presence of the patient in a dental facility.

The reimbursement for procedures rendered via CDT code D9996 – asynchronous teledentistry – will be reimbursed based upon the applicable CDT procedure code(s) being provided. Transmission costs associated with store and forward are not payable per Section 5 – Manual of Criteria and Schedule of Maximum Allowances.

For more information about the Department of Health Care Services' telehealth policy, please refer to the "Medicine: Telehealth" section of the Medi-Cal Provider Manual.

Consent

In addition, Medi-Cal providers must also inform the patient about the use of teledentistry and obtain verbal or written consent from the patient for the use of teledentistry as an acceptable mode of delivering dental services. The consent shall be documented in the patient's dental record (Business and Professionals Code Section 2290.5(b)) and be available to the Department upon request.

For teledentistry services or benefits delivered via asynchronous store and forward, providers must also meet the requirements in state statute (Welfare and Institutions Code [WIC] Section 14132.725[b]).

A member receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of the consultation or within 30 days of the original consultation.

Synchronous or Live Transmissions
Synchronous interaction, or live transmission, is a real-time interaction between a member and a provider located at a distant site. Live transmissions are limited to 90 minutes per member per provider, per day. Please note, live transmissions may be provided at the member's request or if the health care provider believes the service is clinically appropriate.

All dental information transmitted during the delivery of Medi-Cal covered benefits or services via a telehealth modality must become part of the patient's dental record maintained by the Medi-Cal provider at the distant site.

Billing for Teledentistry

Billing for Asynchronous Store and Forward (D9996)

Limited Medi-Cal dental services may be rendered via asynchronous store-and-forward using Current Dental Terminology (CDT) code D9996 (Teledentistry – Asynchronous; Information stored and forwarded to dentist for subsequent review), which identifies the services as teledentistry. CDT code D9996 is not reimbursable; instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code to be paid according to the Schedule of Maximum Allowance (SMA). Applicable CDT procedure codes are appropriate services found in the diagnostic (D0100 - D0999) and

preventive (D1000 - D1999) service categories only. Teledentistry is NOT allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the teledentistry modality codes and D9430 which can only be rendered through Synchronous Teledentistry (D9995).

Billing for Synchronous or Live Transmissions (D9995)

As part of the CDT-19 update, teledentistry CDT code D9995 (Teledentistry-Synchronous; Real-Time Encounter) replaced CDT code D9999 (and D0999). For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render limited services via synchronous/live transmission teledentistry, so long as such services are within their scope of practice, when billed using CDT code D9995 for dates of service on or after May 16, 2020. CDT code D9995 can be billed as a standalone synchronous teledentistry procedure code. The following is Medi-Cal's teledentistry policy for synchronous/live transmissions:

- CDT code D9995 is a per-minute, $.24/minute procedure payable up to maximum of 90 minutes.
- CDT code D9995 is for synchronous, meaning any telephone call or video call/chat, teledentistry encounter.
- CDT Code D9995 is payable once per date of service per patient, per provider.
- CDT code D9995 is for Medi-Cal patient-initiated contact with a Medi-Cal dental provider. This code is not for:
    - Dental assistant time
    - Dental hygienist time
    - Provider-initiated calls to the patient
    - Time spent contacting pharmacies on a patient's behalf
- CDT code D9995 should be billed with the number of minutes noted in the "Quantity" field of the claim, or the documentation should clearly state the number of minutes being requested.

Billing for Safety Net Clinics

For policy and billing information specific to Safety Net Clinics (Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services Memorandum of Agreement 683 Clinics) please refer to those sections of the Medi-Cal Provider Manual (Rural and Indian Health).

Emergency Services

Title 22, CCR, Section 51056, states as follows:

(a) Except as provided in subsection (b), “emergency services” means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(b) For purposes of providing treatment of an emergency medical condition to otherwise eligible aliens pursuant to Welfare and Institutions Code Section 14007.5(d), “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

(1) Any service classified as an emergency, which would have been subject to prior authorization had it not been so classified, must be supported by a physician’s or dentist’s statement which describes the nature of the emergency including relevant clinical information about the patient’s condition, and states why the emergency services rendered were considered to be immediately necessary. A mere statement that an emergency existed is not sufficient. It must be comprehensive enough to support a finding that an emergency existed. Such statement shall be signed by a physician or dentist who had direct knowledge of the emergency described in this statement.

(2) The Department may impose post service prepayment audit as set forth in Section 51159(b), to review the medical necessity of emergency services provided to members. The Department may require providers to follow the procedures for obtaining authorization on a retroactive basis as the process for imposing post-service prepayment audits. Requests for retroactive authorization of emergency services must adequately document the medial necessity of the services and must justify why the services needed to be rendered on an emergency basis.

(d) Program limitation set forth in Section 51304 and 51310 are not altered by this section.

Within the scope of dental benefits under the program, emergency services may comprise of those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Examples of emergency conditions may include, but are not limited to, the following:

- High risk-to-life or seriously disabling conditions, such as cellulitis, oral hemorrhage, and traumatic conditions.
- Low risk-to-life or minimally disabling conditions, such as painful low grade oral-dental infections, near pulpal exposures, fractured teeth or dentures, where these conditions are exacerbated by psychiatric or other neurotic states of the patient.

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

OBRA members are newly legalized amnesty aliens and/or undocumented aliens who are otherwise eligible for Medi-Cal benefits but are not permanent U.S. residents. These members have limited benefits and are only eligible for emergency dental services; they can be identified by their limited scope aid code.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part.

The emergency must be certified in accordance with Section 51056 of Title 22, CCR.

Please note that TARs are not allowed and may not be submitted for these members. If a TAR is submitted for any of the procedures described below, it will be denied.

The following are identified as emergency dental procedures for OBRA members: D0220, D0230, D0250, D0260, D0290, D0330, D0502, D0999, D2920, D2940, D2941, D3220, D3221, D6092, D6093, D6930, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7490, D7510, D7511, D7520, D7521, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7810, D7820, D7830, D7910, D7911, D7912, 7979, D7980, D7983, D7990, D9110, D9210, D9222, D9223, D9230, D9239, D9243, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9920, D9930, D9951.

When applicable, necessary documentation and/or radiographs to justify the emergency procedure must be submitted with the claim.

When the procedures listed above are provided, an emergency certification statement is always required. This statement must be either entered in the "Comments" area (Field 34) on the claim form or attached to the claim. It must:

1. Describe the nature of the emergency, including clinical information pertinent to the patient's condition; and
2. Explain why the emergency services provided were considered immediately necessary. The statement must be signed by the dentist providing the services (in the "Comments" area or on the attached statement) and must provide enough information to show the existence of an emergency dental condition and need for immediate treatment. Merely stating an emergency existed or that the patient was in pain is insufficient.

Other Health Coverage

Medi-Cal Dental follows the regulations in California Code of Regulations (CCR), Title 22, which require full utilization of benefits from all other carriers first. This means Medi- Cal Dental is considered the secondary carrier and can only pay up to the maximum amount allowed for covered benefits. Medi-Cal Dental will make payment only if the primary carrier pays less than the maximum Medi-Cal Dental allowance.

After billing the other coverage carrier, providers should submit a claim to Medi-Cal Dental along with the Explanation of Benefits/Remittance Advice (EOB/RA), Proof of Denial letter, or fee schedule from the other insurance carrier. Medi-Cal Dental will not accept "no other dental coverage" written on the claim, NOA for payment, RTD or CIF. Medi-Cal Dental will apply the coinsurance or deductible to each service in the individual amounts indicated on the EOB/RA and fee schedule; if the other coverage carrier has applied the coinsurance/deductible amount to the claim as a whole, Medi- Cal Dental will distribute the amount equally among all services listed on the claim when calculating payment for covered services. Medi-Cal Dental will pay the difference between the amount the other coverage carrier paid for the service plus the appropriate coinsurance/deductible amount applied to that service, and the Medi-Cal Dental allowed amount for the service. Providers may not bill Medi-Cal member directly for any services that are covered by Medi-Cal other than their Medi-Cal co pay, if applicable.

Note: Insurance information must be submitted for a claim for payment but is not required for a TAR.

Prepaid Health Plan (PHP)/Health Maintenance Organization (HMO)

When a Medi-Cal member has a PHP or HMO as other health coverage, he or she must use the plan facilities for regular dental care. Providers should bill the appropriate carrier for out-of-area services or emergency treatment covered by the member's PHP or HMO.

The following are other health coverage codes:

OHC	Health Coverage Type
A*	Pay and Chase (applies to any carrier)
C	Military Benefits Comprehensive
F	Medicare Part C Health Plan
G	Medical Parolee
H	Multiple Plans Comprehensive Institutionalized
K	Kaiser
L	Dental only policy
P	PPO/PHP/HMO/EPO not otherwise specified
V**	Any carrier other than the above (includes multiple coverage)
W	Multiple Plans Non-Comprehensive

*If "A" is the MEDS cost avoidance code for a member, providers are allowed, but not required, to bill the OHC carrier prior to billing Medi-Cal.
** As of January 1, 2017, OHC code V is only to be used for historical reference.

Providers should note that even though the other health coverage code indicates a PHP/HMO, the dental carrier may not be a PHP or HMO.

For Medi-Cal Dental to correctly process claims submitted for payment, a Remittance Advice/Explanation of Benefits (RA/EOB), fee schedule or denial of service letter must accompany the claim to verify the other coverage carrier is a PHP/HMO. Providers billing Medi-Cal Dental for services not included in the member's PHP/HMO plan must submit an RA/EOB, fee schedule or denial letter showing that the PHP/HMO was billed first.

Beginning July 1, 2020, if the recovery contractor identifies claims that Medi-Cal paid when the member had OHC liable for payment of dental services, the recovery contractor will request the OHC carrier submit payment to DHCS. In the event DHCS pays for dental services where an OHC carrier is later identified, Third Party Liability and Recovery Division (TPLRD) will utilize their recovery contractor to pursue recovery of these claims.

If the OHC carrier issues payment to DHCS, the carrier may provide an EOB to the policyholder under which the Medi-Cal member is covered. EOBs are generated as part of the OHC carrier's obligation to inform its policyholders of claims processed on their behalf. The EOB is not a DHCS claim or bill and the OHC EOB process will not affect services to Medi-Cal members or payments to providers.

Providers should not receive payment from any OHC carrier due to work performed by TPLRD's recovery contractor. If providers receive a check from an OHC carrier that is payable to them as the result of a recovery effort by the contractor, providers should return the check to the OHC carrier. If providers receive payment from an OHC carrier payable to DHCS or TPLRD's recovery contractor, providers should forward the check and any supporting documents to:

Bank of America
P.O. Box 742635
Los Angeles, CA 90074-2635

Child Health and Disability Prevention (CHDP) Gateway

On July 1, 2003, Child Health and Disability Prevention (CHDP) medical providers (not dental providers) began pre-enrolling eligible low-income children under 19 years of age into the new CHDP Gateway. CHDP Gateway providers encourage parents to apply for health care coverage for their children through Medi-Cal or Healthy Families. The children are eligible to receive Full Scope, fee-for-service Medi-Cal and Medi-Cal dental benefits during the month of application and the following month, or until the processing of their application is complete. Medi-Cal Dental reimbursement rates for children eligible for this temporary coverage are the same as the usual Medi-Cal dental rates.

Children who are not eligible for either program will continue to receive CHDP services in accordance with the CHDP periodicity table.

Since the Gateway began, several issues have arisen that may be of interest to Medi-Cal dental providers:

- Because some children may be eligible for only 1-2 months, it is very important for children with temporary Medi-Cal eligibility to be seen as quickly as possible. A number of offices and clinics have responded by setting aside a block of time to see these children.
- Children enrolled through the Gateway will ordinarily receive their BIC ID card within 10 days of enrollment. In the interim, they will have an "immediate eligibility document," which will be a copy of a printout from an Internet Website. This document displays the member's BIC ID number and is an acceptable form of identification that should be accepted until the BIC ID card is received. Regardless of whether the member presents a BIC ID card or a paper immediate eligibility document, all providers, including Children's Treatment Program (CTP) providers, must always check a member's eligibility status at each visit. The PM160 form is insufficient documentation for participation in the CHDP Gateway.
- The immediate eligibility document can contain several different responses, so it is important to read the response carefully. All providers participating in the CHDP Gateway, including CTP providers, must check eligibility for every member at every visit, regardless of what the response says. The PM160 form is insufficient.

- Children who are determined ineligible for temporary Medi-Cal coverage through the Gateway may be assigned other emergency or pregnancy-related Medi-Cal aid codes. If a child switches dentists because they were unable to complete treatment prior to termination of their temporary Medi-Cal coverage, Medi-Cal Dental encourages the child's provider to provide the child's treatment plan and radiographs to their new dentist to prevent unnecessary duplication of costs.
- Because of the short period of eligibility for some children, Medi-Cal Dental encourages providers to allow their names and phone numbers to be distributed to CHDP medical providers. Providers willing to do this should call the local CHDP office to be included on a referral list. Access the local CHDP office here. Also, if Medi-Cal dental providers are able to accommodate children eligible for the Gateway on short notice, notify the CHDP medical providers so they will know of your willingness to see these children relatively quickly. (For additional eligibility procedures for CHDP, please refer to the Eligibility: CHDP Services document.)

Altered Cards and Other Abuses of Medi-Cal Dental Fraud, Help Stop Altered Cards and Other Abuses

The Department is requesting that dental providers be reminded that all member information is confidential and must be protected from disclosure to unauthorized personnel. Member identification includes the following:

- Member's name
- Address
- Telephone number
- Social Security Number
- Medi-Cal identification number

Protecting confidential information is especially important for providers of inpatient care billing and third-party insurance organizations when utilizing independent billing agencies, as well as employees who appear to be inappropriately accessing such information.

Dental providers should not accept any Medi-Cal identification card that has been altered in any way. If a member presents a paper or plastic card that is photocopied or contains erasures, strikeouts, white-outs, type-overs, or appears to have been altered in any other way, the provider should request that the member obtain a new card from his or her county social services office prior to performing services. Health care providers are encouraged to report evidence of fraud to the Attorney General's Medical Fraud Hotline at (800) 722-0432. Any provider who suspects a member of abusing Medi-Cal Dental may call (800) 822-6222. Situations where abuse of the program may be suspected include:

- Use of another person's Medi-Cal identification card;

- Presenting an altered card;
- Attempting to obtain excessive or inappropriate drugs.

Misuse of Benefits Identification Card

The Department's Medical Review Branch has increased the number of replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. This process may be further escalated as other misuses of BICs are discovered.

If a provider receives a response during the eligibility verification process that states "current BIC ID and issue date required", the provider must ask the member for his/her new card.

Attaching a copy of the BIC card for documentation purposes will **not be accepted**.

Prevention of Identity Theft

To prevent identity theft, the Department requires all providers to avoid using a member's Social Security Number (SSN) whenever possible and reminds them that SSNs are not permitted on forms submitted for payment. Claims or TARS submitted with SSNs will be denied.

When submitting TAR/Claim forms to Medi-Cal Dental, providers should use the 14-character ID number from the BIC.

Member Complaint or Grievance Procedures

A Medi-Cal member with a complaint or grievance concerning scope of benefits, quality of care, modification or denial of a TAR/Claim form, or other aspect of services provided under the Medi-Cal Dental must direct the complaint or grievance as follows:

Initial Appeal to Provider

The member should initiate action by submitting the complaint or grievance to the provider, identifying the complaint or grievance by specifically describing the disputed service, action, or inaction. The provider responsible for the dental needs of the member should attempt to resolve the complaint or grievance within the parameters of Medi-Cal Dental.

Notification to Medi-Cal Dental

When action at the provider level fails to resolve the complaint or grievance, the member should contact the Telephone Service Center at (800) 322-6384, identify himself/herself and the provider involved, and specifically describe the disputed services, action, or inaction. Medi-Cal Dental will make every effort to resolve the

problem at this level. Medi-Cal Dental may refer the member back to the provider for resolution of the problem. The member may also download and complete the Medi-Cal Dental Complaint Form (sample below) and return it to Medi-Cal Dental at the address indicated on the form.

If a member files a complaint over the phone and the complaint was not resolved during the call, they will receive a follow up call for further assistance. If the member's complaint cannot be resolved during the follow up call, Medi-Cal Dental will help them download the complaint form from the Medi-Cal Dental website here. Medi-Cal Dental can also mail the form to the member if that is the preferred method. Once the member completes and signs the form, they must mail it to Medi-Cal Dental at the address printed on the form.

Medi-Cal Dental will acknowledge the written complaint or grievance within three calendar days of receipt. The written complaint or grievance may be referred to a

Medi- Cal dental consultant, who will determine the next course of action, which could include contacting the patient and/or provider, referring the patient to a clinical screening examination by a Medi-Cal Dental Clinical Screening Dentist, or referral to the appropriate peer review body.

When a copy of the member's chart and other pertinent information is requested from a provider's office, it is important that this information be submitted to Medi-Cal Dental within the time frame indicated on the request to avoid potential recoupment of funds previously paid for the service(s) at issue.

Medi-Cal Dental will send a letter summarizing its conclusion and reasons substantiating the decision to the patient within 30 days of the receipt of the complaint or grievance. If it is determined that there is a need to recoup funds for previously paid service(s), Medi-Cal Dental will issue the provider a written notification indicating the specific reasons for the recoupment. If a member is not able to make their scheduled clinical screening the 30 days may be extended.

If treatment the member's dental provider requested has been denied or modified, or if the member is unhappy with the resolution of their complaint about a denied service, they may request a State Hearing through the California Department of Social Services (CDSS) by writing to the:

California Department of Social Services
State Hearings Division
PO Box 944243
Sacramento, CA 94244-2430

Or by calling:

800-743-8525

The following pages include the forms to submit for member complaints. The form can also be found on the Medi-Cal Dental website here.

The Department of Health Care Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Department of Health Care Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To learn more about the nondiscrimination policy, please visit the Department of Health Care Services website here.

Member Medi-Cal Dental Complaint Form (Page 1)

Member Medi-Cal Dental Complaint Form

DHCS | Medi-Cal Dental

DATE: _____

NAME: _____
ADDRESS: _____
CITY: _____ ST: ____ ZIP: _____

MEDI-CAL DENTAL COMPLAINT FORM

Please fill in the form below and describe your questions or complaints completely. This information is important and necessary to research and resolve your questions or complaints.

STATE OF CALIFORNIA MEDI-CAL
BENEFITS IDENTIFICATION CARD NUMBER: _____

TELEPHONE NUMBER: (_____) _____

MESSAGE TELEPHONE NUMBER: (_____) _____

YOUR REPRESENTATIVE (if not yourself):

NAME: _____

ADDRESS: _____

CITY: _____, STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

YOUR DENTAL PROVIDER'S NAME: _____

NAME: _____

ADDRESS: _____

CITY: _____, STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

P.O Box 15539 • Sacramento, CA 95852-0609 • (800) 322-6384

DHCS | Medi-Cal Dental

MEDI-CAL DENTAL COMPLAINT FORM (PAGE 2)

TYPE OF COMPLAINT:

_____ Dentist service was incomplete or unsatisfactory

_____ Clinical Screening process was unsatisfactory

_____ Other

_____ Comments (Please describe your questions or complaints/ grievances completelyhere. Use the reverse side of this form or additional pages if you need additional space.)

_____

_____

_____

_____

_____

PLEASE SIGN AND DATE THIS FORM:

It may be necessary to obtain your medical records from your dental care provider. Your signature below authorizes release of your dental records to Medi-Cal Dental.

SIGNATURE_____DATE_____

Return this form to:

Medi-Cal Dental Program
Member Services Group
P.O. Box 15539
Sacramento, CA 95852-1539

When we receive this information, we will research your questions or complaints/grievances and notify you of our findings. If it is necessary for you to appear for a clinical examination in order to resolve this matter, we will notify you in writing of the date, time, and location of this appointment.

P.O Box 15539 • Sacramento, CA 95852-0609 • (800) 322-6384

State Hearing

According to California Code of Regulations (CCR), Title 22, Section 50951:

Applicants or members shall have the right to a State hearing if dissatisfied with any action or inaction of the county department, the Department of Health Care Services or any person or organization acting in behalf of the county or the Department relating to Medi-Cal eligibility or benefits.

Authorization of Services Through the State Hearing Process

Services can be authorized through the State Hearing process in two ways:

1. A conditional withdrawal; or
2. A granted decision.

Conditional Withdrawal

A conditional withdrawal can be offered to the member upon receipt of additional information from either the member or the dentist. If the member agrees to the conditions of the withdrawal, a pink authorization letter is mailed to him/her. The member may then take the authorization to the Medi-Cal dental provider of his/her choice. In order to be paid for services provided, the treating provider is responsible to:

1. Be an enrolled Medi-Cal dental provider.
2. Verify the patient's eligibility.
3. Provide ONLY the service(s) authorized within the 365 days of the date on the letter.
4. Submit a claim for payment within 60 calendar days from the date of the last completed service provided within the authorization period. The claim must include the original pink authorization letter bearing the original signature. Mail the claim for payment to:

   Medi-Cal Dental
   California Medi-Cal Program
   Attn: State Hearings
   PO Box 13898
   Sacramento, CA 95853

Granted Decision

If an administrative law judge determines a denied service should be authorized, the judge will issue a GRANTED DECISION. Through the action, the member is authorized to take the decision to the Medi-Cal dental provider of his/her choice to receive services. In order to be paid for services provided, the treating provider is responsible to:

1. Be an enrolled Medi-Cal dental provider.
2. Verify the patient's eligibility. Provide ONLY the service(s) authorized in the "ORDER" section of the decision within 365 calendar days of the signed order.

3. Submit a claim for payment within 60 calendar days from the date of the last completed service performed within the authorization period. The claim must include the Granted Decision and should be mailed to the following address:

   Medi-Cal Dental
   California Medi-Cal Program
   Attn: State Hearings
   PO Box 13898
   Sacramento, CA 95853

Contacting Medi-Cal Dental to Postpone or Withdraw a State Hearing

The Department of Social Services (DSS) has implemented a phone number for providers and members wishing to postpone or withdraw a State Hearing. The toll-free phone number is
(855) 266-1157. This number may also be used to make a general inquiry about a State Hearing that has already been filed.

To make an oral request to file a State Hearing, providers and members should continue to call DSS toll-free at (800) 952-5253.

Aid Codes

The following aid codes identify the types of services for which different Medi-Cal/CMSP/
CCS/GHPP members are eligible.

More information about OBRA and IRCA aid codes can be found on the Medi-Cal website > Publications > Provider Manuals > Part 1-Medi-Cal Program and Eligibility > OBRA and IRCA (obra).

Special Indicators: These indicators, which appear in the aid code portion of the county ID number, help Medi-Cal identify the following:

IE Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR Responsible Relative: An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

Aid Code	Benefits	SOC	Program/Description
0A	Full Scope	No	Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	HF services only (no Medi-Cal)	No	Access for Infants and Mothers (AIM) - Infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
0E	Full Scope	No	Medi-Cal Access Prog Preg Women >213% through 322%
0F	Full Scope	No	Five Month transitional food stamp program. This aid code is for households who are terminating their participation in the CalWORKs program without the need to re-establish food stamp eligibility.
0G	Full Scope	No	MCAP Pregnant Woman >213% = <322% FPL FFS
0M	Full Scope	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.
0N	Full Scope	No	AE of temporary, Full Scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. No time limit.

Aid Code	Benefits	SOC	Program/Description
0P	Full Scope	No	Full scope, no SOC Medi-Cal only for females 65 years of age and younger who are diagnosed with breast and/or cervical cancer and found in need of treatment, who have no creditable health insurance coverage and who are eligible for the duration of treatment.
0R	Restricted Services	No	Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for all males and females (regardless of age or immigration status). These individuals must have high-cost other health coverage cost-sharing insurance (over $750/year), have a diagnosis of breast (payment limited to 18 months) and/or cervical (payment limited to 24 months) cancer, and are found in need of treatment.
0T	Restricted Services	No	Provides payment of 18 months of breast and 24 months of cervical cancer treatment services for all aged males and females who are not eligible under aid codes 0P, 0R, or 0U, regardless of citizenship, that are diagnosed with breast and/or cervical cancer and found in need of treatment. This aid code does not contain anyone with other creditable health insurance, regardless of the amount of coinsurance. Does not cover individuals with expensive creditable insurance or anyone with unsatisfactory immigration status.
0U	Restricted Services	No	Provides services only for females with unsatisfactory immigration status, who are 65 years of age or younger, diagnosed with breast and/or cervical cancer and are found in need of treatment. These individuals are eligible for federal Breast and Cervical Cancer Treatment Program (BCCTP) for emergency services for the duration of the individual's treatment. State-only breast (payment limited to 18 months) and cervical (payment limited to 24 months) cancer services, pregnancy-related services and LTC services. Does not cover individuals with other creditable health insurance.
0V	Limited Scope	No	Provides Emergency, Long-Term Care, and Pregnancy-related services, with no share of cost, to individuals no longer eligible for the Breast and Cervical Cancer Treatment Program.

Aid Code	Benefits	SOC	Program/Description
0W	Full Scope	No	BCCTP – Trans 65+ Full Scope
0X	Restricted to pregnancy and emergency services	No	BCCTP – Trans 65+ Undoc, ES, LTC, Preg
0Y	Restricted to pregnancy and emergency services	No	BCCTP – Trans65+ Undoc, ES. LTC. Preg
01	Full Scope	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.
02	Full Scope	Y/N	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.
03	Full Scope	No	Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.
04	Full Scope	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC) (non-FFP). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.
05	None	No	SERIOUSLY EMOTIONALLY DISTURBED CHILDREN
07	Full Scope	No	A cash grant program to facilitate the ongoing adoptive placement of hard-to-place NMDs, whose initial AAP payment occurred on or after age 16 and are over age 18 but under age 21, who would require permanent foster care placement without such assistance.

Aid Code	Benefits	SOC	Program/Description
08	Full Scope	No	Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.
09	None	No	FOOD STAMP PROGRAM - PARTICIPANTS
1A	None	No	Aged Cash Assistance Program for Immigrants (CAPI) – Qualified Aliens
1D	Full Scope	No	Aged – In-Home Support Services (IHSS). Covers aged individuals discontinued from the IHSS residual program for reasons other than the loss of Supplemental Security Income/State Supplemental Payment (SSI/SSP) until the county determines their Medi-Cal eligibility.
1E	Full Scope	No	Craig v. Bonta Continued Eligibility for the Aged. Aid Code 1E covers former SSI members who are aged (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
1F	None	Yes	PERSONAL CARE SERVICES PROGRAM
1H	Full Scope	No	Federal Poverty Level – Aged (FPL-Aged). Provides Full Scope (no Share of Cost) Medi-Cal to qualified aged individuals/couples.
1U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Aged (Restricted FPL-Aged). Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/couples who do not have satisfactory immigration status.
1X	Full Scope	No	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with no share of cost and with federal financial participation.

Aid Code	Benefits	SOC	Program/Description
1Y	Full Scope	Yes	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with a Share of Cost and with federal financial participation.
10	Full Scope	No	SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.
11	None	No	AID TO THE AGED - SERVICES ONLY
12	None	No	AID TO THE AGED - SPECIAL CIRCUMSTANCES
13	Full Scope	Y/N	Aid to the Aged – LTC (FFP). Covers persons 65 years of age or older who are medically needy and in LTC status.
14	Full Scope	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.
16	Full Scope	No	Aid to the Aged – Pickle Eligible (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the Lynch v. Rank lawsuit.
17	Full Scope	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. SOC required.
18	Full Scope	No	Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.
2A	Full Scope	No	Abandoned Baby Program. Provides Full Scope benefits to children up to three months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2C	Full Scope	No	CCHIP above 266% - 322% FPL, age 0 < 19

Aid Code	Benefits	SOC	Program/Description
2D	Full Scope	No	BLIND DISCONTINUED IHSS RESIDUAL
2E	Full Scope	No	Craig v. Bonta Continued Eligibility for the Blind. Aid code 2E covers former SSI members who are blind (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
2F	None	Yes	PERSONAL CARE SERVICES PROGRAM
2H	Full Scope	No	Blind - Federal Poverty Level - Full
2L	None	N/A	IHSS - PLUS WAIVER
2M	None	N/A	IHSS - PERSONAL SERVICES
2N	None	N/A	IHSS - RESIDUAL
2V	Full Scope	No	TVCAP RMA Medi-Cal NO SOC
2P	Full Scope	No	ARC Program - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who do not qualify for state CalWORKs.
2R	Full Scope	No	ARC Program - Non-Minor Dependent (NMD) - Medi-Cal coverage for foster youth 18 to 21 years of age (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who does not qualify for state CalWORKs.
2S	Full Scope	No	ARC Program - Federal CalWORKs - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for federal CalWORKs.
2T	Full Scope	No	ARC Program - State CalWORKs - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for state CalWORKs.

Aid Code	Benefits	SOC	Program/Description
2U	Full Scope	No	ARC Program - State CalWORKs NMD - Medi-Cal coverage for foster youth 18 to 21 years of age (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who qualifies for state CalWORKs.
2X	Full Scope	No	LIMITED TERM REINSTATEMENT
20	Full Scope	No	SSI/SSP Aid to the Blind (FFP). A cash assistance program, administered by the SSA, which pays a cash grant to needy blind persons of any age.
21	None	No	AID TO THE BLIND - SERVICES ONLY
22	None	No	AID TO THE BLIND - SPECIAL CIRCUMSTANCES
23	Full Scope	Y/N	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.
24	Full Scope	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.
26	Full Scope	No	Aid to the Blind – Pickle Eligible (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit. (See Aid Code 16 for definition of Pickle eligible.)
27	Full Scope	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. SOC is required of the members.
28	Full Scope	No	Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See Aid Code 18 for definition of eligibility for IHSS.)

Aid Code	Benefits	SOC	Program/Description
3A	Full Scope	No	Safety Net - All Other Families, CalWORKs, Timed-Out, Child-Only Case. This program provides for continued cash and Medi-Cal Dental coverage of children whose parents have been discontinued from cash aid and removed from the assistance unit (AU) due to reaching the CalWORKs 60-month time limit without needing a time extender exception.
3C	Full Scope	No	Safety Net - Two-Parent, CalWORKs Timed-Out, Child-Only Case. This program provides for continued cash and Medi-Cal Dental coverage of children whose parents have been discontinued from cash aid and removed from the AU due to reaching the CalWORKs 60-month time limit without meeting a time extender extension.
3D	Full Scope	No	CalWORKs Pending, Medi-Cal Eligible. Provides Medi-Cal coverage for a maximum period of four months to new CalWORKs recipients.
3E	Full Scope	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3F	Full Scope	No	Two Parent Safety Net & Drug/Fleeing Felon Family.
3G	Full Scope	No	AFDC-FG (State only) (non-FFP cash grant FFP for Medi-Cal eligible). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent, who does not meet all federal requirements, but State rules require the individual(s) be aided. This population is the same as Aid Code 32, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.

Aid Code	Benefits	SOC	Program/Description
3H	Full Scope	No	AFDC-FU (State only) (non-FFP cash grant FFP for Medi-Cal eligible). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home. This population is the same as Aid Code 33, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3J	None		CalWORKs – Diversion AF
3K	None		CalWORKs – Diversion 2P
3L	Full Scope	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3M	Full Scope	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3N	Full Scope	No	AFDC – Mandatory Coverage Group Section 1931(b) (FFP). Section 1931 requires Medi-Cal be provided to low-income families who meet the requirements of the Aid to Families with Dependent Children (AFDC) State Plan in effect July 16, 1996.
3P	Full Scope	No	AFDC Unemployed Parent (FFP cash) – Aid to families in which a child is deprived because of the unemployment of a parent living in the home and the unemployed parent meets all federal AFDC eligibility requirements. This population is the same as Aid Code 35, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.

Aid Code	Benefits	SOC	Program/Description
3R	Full Scope	No	Aid to Families with Dependent Children (AFDC) – Family Group (FFP) in which the child/children is/are deprived because of the absence, incapacity or death of either parent. This population is the same as Aid Code 30, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3S	None		CA Registered Domestic Partner
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full Scope	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3V	Restricted to pregnancy and emergency services	No	Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.
3W	Full Scope	No	Temporary Assistance for Needy Families (TANF) - Timed out, mixed case. Recipients who reach the TANF 60-month time limit, remain eligible for CalWORKs and the family includes at least one non-federally eligible recipient.
3X	None		CalWORKs – Diversion 2P – State only
3Y	None		CalWORKs – Diversion 2P – State only
30	Full Scope	No	AFDC-FG (FFP). Provides aid to families with dependent children in a family group in which the child/children is/are deprived because of the absence, incapacity or death of either parent.
31	None	No	AFDC FAMILY GROUP - SERVICES ONLY

Aid Code	Benefits	SOC	Program/Description
32	Full Scope	No	TANF-Timed out. Recipients who have reached their TANF 60-month time limit and remain eligible for CalWORKs.
33	Full Scope	No	AFDC – Unemployed Parent (State-only program) (non-FFP cash grant FFP for Medi-Cal eligible). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home.
34	Full Scope	No	AFDC-MN (FFP). Covers families with deprivation of prenatal care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.
35	Full Scope	No	AFDC-U (FFP cash). Provides aid to families in which a child is deprived because of unemployment of a parent living in the home, and the unemployed parent meets all federal AFDC eligibility requirements.
36	Full Scope	No	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.
37	Full Scope	Yes	AFDC-MN (FFP). Covers families with deprivation of prenatal care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. SOC required of the members.
38	Full Scope	No	Continuing Medi-Cal Eligibility (FFP). Edwards v Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate Notice of Action sent.

Aid Code	Benefits	SOC	Program/Description
39	Full Scope	No	Initial Transitional Medi-Cal (TMC) – Six Months Continuing Eligibility (FFP). Provides coverage to certain clients subsequent to AFDC cash grant discontinuance due to increased earnings, increased hours of employment or loss of the $30 and 1/3 disregard.
4A	Full Scope	No	Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).
4C	Full Scope	No	AFDC-FC Voluntarily Placed (Fed) (FFP). Provides financial assistance for those children who need substitute parenting and who have been voluntarily placed in foster care.
4D	None	No	ADAM
4E	Full Scope	No	Hospital PE Former Foster Care Up to age 26.
4F	Full Scope	No	Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.
4G	Full Scope	No	Kin-GAP. State-only program for children in relative placement receiving cash assistance.
4H	Full Scope	No	Foster Care Children in CALWORKS.
4K	Full Scope	No	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.
4L	Full Scope	No	Foster Care Children In 1931(B)
4M	Full Scope	No	Former Foster Care Children (FFCC) 18 through 20 years of age. Provides Full Scope Medi-Cal benefits to former foster care children who were receiving benefits on their 18th birthday in Aid Codes 40, 42, 45, 4C and 5K and who are under 21 years of age.
4N	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for foster care placement, living with an approved CalWORKs relative who is not eligible for Kin-GAP or foster care

Aid Code	Benefits	SOC	Program/Description
4P	None	No	CalWORKs Family Reunification – ALL FAMILIES, provides for the continuance of CalWORKs services to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
4R	None	No	CalWORKs FAMILY REUNIFICATION – TWO PARENTS, provides for the continuation of CalWORKs services to two-parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
4S	Full Scope	No	Serves former foster care NMDs over age 18, but under age 21, by moving them from foster care placements to more permanent placement options through the establishment of a relative guardianship that occurred on or after age 16. (Also "includes youth aged 18 but under age 21 based on a disability.")
4T	Full Scope	No	IV-E KinGAP Full Scope No SOC to 21 years-old with exceptions
4U	Full Scope	No	FFCC Optional Coverage Group
4V	Full Scope	Yes	TVCAP RMA Medi-Cal SOC
4W	Full Scope	No	Covers NMDs age 18 but under age 21, eligible for extended KinGAP assistance based on a disability or based on the establishment of the guardianship that occurred on or after age 16. Non-Title IV-E KinGAP must have a full Medicaid eligibility determination.
40	Full Scope	No	AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who need substitute parenting and who have been placed in foster care.
41	None	No	AFDC - FOSTER CARE - SERVICES ONLY
42	Full Scope	No	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.
43	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for state-only foster care placement.

Aid Code	Benefits	SOC	Program/Description
44	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant (FFP) United States Citizen/U.S. National and aliens with satisfactory immigration status including lawful Permanent Resident Aliens/Amnesty Aliens and PRUCOL Aliens. Provides family planning, pregnancy-related and postpartum services for any female if family income is at or below 200 percent of the federal poverty level.
45	Full Scope	No	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.
46	Full Scope	No	Foster Children Placed in Ca from out of state
47	Full Scope	No	Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to 1 year old and continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant – Covers aliens who do not have lawful permanent resident, PRUCOL, or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.
49	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for federal foster care placement.
5A	None		EA Seriously Emotionally Disturbed
5C	Full Scope	No	HFP to Medi-Cal Transitional PE-No Premium
5D	Full Scope	No	HFP to Medi-Cal Transitional PE-Premium Payment
5E	Full Scope	No	HF to Medi-Cal PE-No SOC

Aid Code	Benefits	SOC	Program/Description
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers pregnant alien women who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
5G	None	No	OBRA Recipients – Undocumented Aliens
5J	Restricted Services	No	Members, whose linkage has to be redetermined under Senate Bill 87 (SB 87) requirements, are receiving restricted services due to unsatisfactory immigration status, with no SOC, and whose potential new linkage is disability.
5K	Full Scope	No	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.
5L	Full Scope	No	Emergency Assistance Foster Care – Non-Federal
5M	None	No	100% Program OBRA Child
5N	None	No	OBRA Recipients – Undocumented Aliens
5R	Restricted Services	Yes	Members, whose linkage has to be re-determined under SB 87 requirements, are receiving restricted services with a SOC, and whose potential new linkage is disability.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.
5V	Full Scope	No	TVCAP MEDI-CAL RULES NO SOC, Emergency Services
5W	Restricted to pregnancy and emergency services	No	Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
5X	Full Scope	No	Second Year Transitional Medi-Cal (TMC). Provides a second year of Full Scope (no SOC) TMC benefits for citizens and qualified aliens aged 19 and older who have received six months of additional Full Scope TMC benefits under aid code 59 and who continue to meet the requirements of additional TMC. (State-only program.)

Aid Code	Benefits	SOC	Program/Description
50	Restricted to CMSP emergency services only	Y/N	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
51	Full Scope	Yes	IRCA ALIENS - FULL SCOPE BENEFITS
52	Limited Scope	Yes	IRCA ALIENS - EMERGENCY BENEFITS
53	Restricted to LTC services only	Y/N	Medically Indigent – LTC (Non-FFP). Covers persons aged 21 or older and under 65 years of age who are residing in a Nursing Facility Level A or B and meet all other eligibility requirements of medically indigent, with or without SOC.
54	Full Scope	No	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.
55	Restricted to pregnancy and emergency services	No	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color of Law (PRUCOL). LTC services: State-only funds; emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.
56	Full Scope	Y	IRCA AG WKRS - FULL SCOPE BENEFITS
57	Limited Scope	Yes	IRCA AG WKRS - EMERGENCY BENEFITS
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers aliens who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
59	Full Scope	No	Additional TMC – Additional Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the expiration of the $30 plus 1/3 disregard, increased earnings or hours of employment, but eligible for Medi-Cal only, may receive this extension of TMC.
6A	Full Scope	No	Disabled Adult Child(ren) (DAC)/Blindness (FFP).
6C	Full Scope	No	Disabled Adult Child(ren) (DAC)/Disabled (FFP).

Aid Code	Benefits	SOC	Program/Description
6D	Full Scope	Y/N	Disabled – In-Home Support Services (IHSS). Covers disabled individuals discontinued from the IHSS residual program for reasons other than the loss of Supplemental Security Income/State Supplemental Payment (SSI/SSP) until the county determines their Medi-Cal eligibility.
6E	Full Scope	No	Craig v Bonta Continued Eligibility for the Disabled. Aid code 6E covers former SSI members who are disabled (except for persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
6F	None	Yes	PERSONAL CARE SERVICES PROGRAM
6G	Full Scope	No	250 Percent Program Working Disabled. Provides Full Scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.
6H	Full Scope	No	Federal Poverty Level – Disabled (FPL-Disabled) Provides Full Scope (no Share of Cost) Medi-Cal to qualified disabled individuals/couples.
6J	Full Scope	No	Senate Bill (SB) 87 Pending Disability Program. Provides Full Scope, no Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6K	None		CAPI – Non-Qualified Aliens
6M	None		CAPI – Sponsored Aliens
6N	Full Scope	No	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6R) who are appealing their cessation of SSI disability.
6P	Full Scope	No	PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.

Aid Code	Benefits	SOC	Program/Description
6R	Full Scope	Yes	Senate Bill (SB) 87 Pending Disability Program. Provides Full Scope, Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6S	Full Scope	No	State Only – This aid code supplants those that were in Aid Code 65 prior to 8/24/05 - Aid to the Disabled Substantial Gainful Activity/Aged, Blind, Disabled – Medically Needy IHSS (non-FFP). Covers persons who (a) were once determined to be disabled in accordance with the provisions of the SSI/SSP program and were eligible for SSI/SSP but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations. They must also continue to suffer from the physical or mental impairment that was the basis of the disability determination or (b) are aged, blind, or disabled medically needy, and have the costs of IHSS deducted from their monthly income.
6T	None		CAPI – Limited Term Qualified Aliens
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.
6V	Full Scope	No	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.
6W	Full Scope	Yes	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.
6X	Full Scope	No	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
6Y	Full Scope	Yes	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
60	Full Scope	No	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.

Aid Code	Benefits	SOC	Program/Description
61	None	No	AID TO THE DISABLED - SPECIAL CIRCUMSTANCES
62	None	No	DISABLED - LONG TERM CARE
63	Full Scope	Y/N	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.
64	Full Scope	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant but are eligible for Medi-Cal only.
65	Full Scope	Y/N	Katrina – covers eligible evacuees of Hurricane Katrina
66	Full Scope	No	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v Rank lawsuit. No age limit for this aid code.
67	Full Scope	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See Aid Code 64 for definition of Disabled – MN.) SOC is required of the members.
68	Full Scope	No	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See Aid Codes 18 and 65 for definition of eligibility for IHSS).
69	Limited Scope	No	185% Program OBRA – OBRA Infants (FFP)
7A	Full Scope	No	100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
7C	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/ Nonimmigrant Status/[IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy-related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.

Aid Code	Benefits	SOC	Program/Description
7D	Full Scope	No	Hospital Presumptive Eligibility (HPE) for the Aged
7E	Full Scope	No	100% New Entrant Non-Immigrant
7F	Valid for pregnancy verification office visit	No	Presumptive Eligibility (PE) – Pregnancy Verification (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care Services (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive.
7H	Valid only for TB-related outpatient services	No	Medi-Cal Tuberculosis (TB) Program. Covers individuals who are TB-infected for TB-related outpatient services only.
7J	Full Scope	No	Continuous Eligibility for Children (CEC) Program. Provides Full Scope benefits to children up to 19 years of age who would otherwise move to a SOC (Share of Cost).
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC) Program. Provides emergency and pregnancy-related benefits (no SOC) to children up to 19 years of age who would otherwise move to a SOC.
7L	Full Scope	No	ELE 19 through 64 <= 128% FPL - Disabled No Medicare
7M	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors aged 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning.
7N	Valid for Minor Consent services	No	Minor Consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning.

Aid Code	Benefits	SOC	Program/Description
7P	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors age 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning and outpatient mental health treatment.
7R	Valid for Minor Consent services	Y/N	Minor Consent Program (FFP). Covers minors under age 12. Limited to services related to family planning and sexual assault.
7S	Full Scope	No	Cal Fresh Express Lane for Parents Age 19-64, at or below 138% FPL.
7T	Full Scope	No	Free National School Lunch Program (NSLP) Express Enrollment. Children determined by their school, designated as an express enrollment entity, as eligible for express enrollment.
7U	Full Scope	No	Cal Fresh Express Lane for Adults Age 19-64, at or below 130% FPL.
7V	Full Scope	No	Trafficking and Crime Victims Assistance Program (TCVAP). Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
7W	Full Scope	No	Cal Fresh Express Lane Enrollment for Children Age 0-19, at or below 130% FPL.
7X	Full Scope	No	Two months of Healthy Families Program (HFP) Bridge. Provides two calendar months of health care benefits with no SOC to Medi-Cal parents, caretaker relatives, legal guardians, and children who appear to qualify for the Healthy Family Program.
7Y	Full Scope	No	HF to Medi-Cal Bridge (HFP) provides two additional calendar months of HF to adults and children who at the annual review are ineligible for HF and appear to qualify for Medi-Cal.
71	Restricted to dialysis and supplemental dialysis-related services	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP) (Non-FFP). Covers persons of any age who are eligible only for dialysis and related services.

Aid Code	Benefits	SOC	Program/Description
72	Full Scope	No	133 Percent Program. Child-United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
73	Restricted to parenteral hyperalimentation-related expenses	Y/N	Medi-Cal TPN Only Program/Medi-Cal TPN Supplement Program (Non-FFP). Covers persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.
74	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
75	None	No	Asset Waiver Program (Pregnant)
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program. Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.
79	Full Scope	No	Asset Waiver Program (Infant). Provides full Medi Cal benefits to infants up to 1 year, and beyond 1 year when inpatient status, which began before first birthday, continues and family income is between 185 percent and 200 percent of the federal poverty level (State-Only Program).
8A	None	No	QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)
8C	None	No	SPECIFIED LOW INCOME MEDI-CAL MEMBER (SLMB)
8D	None	No	QUALIFYING INDIVIDUAL - 1 PROGRAM (QI-1)

Aid Code	Benefits	SOC	Program/Description
8E	Full Scope	No	Children under the age of 19, apparently eligible for any no-cost Medi-Cal program, will receive immediate, temporary, fee-for-service, Full Scope, no-cost Medi-Cal benefits.
8F	CMSP services only (companion aid code)	Y/N	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
8G	Full Scope	No	Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.
8H	Family PACT (SOFP services only). No Medi-Cal	N/A	Family PACT (also known as SOFP – State Only Family Planning). Comprehensive family planning services for low-income residents of California with no other source of health care coverage.
8L	Full Scope	No	Adult Age Over 19 Presumptive Eligibility Batch
8K	None	No	QUALIFYING INDIVIDUAL - 2 PROGRAM (QI-2)
8N	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8P	Full Scope	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides Full Scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8R	Full Scope	No	100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident/ PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides Full Scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.

Aid Code	Benefits	SOC	Program/Description
8T	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/Nonimmigrant Status/(IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
8U	Full Scope	No	Deemed Eligibility (DE) CHDP Gateway/Medi-Cal. Provides Full Scope no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.
8V	Full Scope	Yes	Deemed Eligibility (DE) CHDP Gateway/Medi-Cal. Provides Full Scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant's birth and SOC was met.
8W	Full Scope	No	Child Health Disability Program (CHDP) Gateway Medi-Cal – Aid Code 8W provides for the pre-enrollment of children into the Medi-Cal program which will provide temporary, no share of cost (SOC), Full Scope Medi-Cal dental benefits. Federal Financial Participation (FFP) for these benefits is available through Title XIX of the Social Security Act.
8X	Full Scope	No	CHDP Gateway Healthy Families – Aid Code 8X provides pre-enrollment of children into the Medi-Cal program. Provides temporary, Full Scope Medi-Cal dental benefits with no SOC until eligibility for the Healthy Families program can be determined. Federal Financial Participation (FFP) for these benefits is available through Title XXI of the Social Security Act.
8Y	CHDP Only	No	CHDP – Aid Code 8Y provides eligibility to the CHDP ONLY program for children who are known to MEDS as not having satisfactory immigration status. There is no Federal Financial Participation for these benefits. This aid code is state funded only.

Aid Code	Benefits	SOC	Program/Description
80	Restricted to Medicare expenses	No	Qualified Medicare Member (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.
81	Full Scope	Y/N	MI-Adults Aid Paid Pending (Non-FFP). Aid Paid Pending for persons over 21 but under 65, with or without SOC.
82	Full Scope	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under Aid Code 82 until age 22 if they have filed for a State hearing.
83	Full Scope	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
84	CMSP services only (no Medi-Cal)	No	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
85	CMSP services only (no Medi-Cal)	Yes	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
86	Full Scope	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent.
87	Full Scope	Yes	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
89	CMSP services only (no Medi-Cal)	Yes	CMSP is administered by Doral Dental Services of California: (800) 341-8478.

Aid Code	Benefits	SOC	Program/Description
9A	BCEDP only	No	The Breast Cancer Early Detection Program (BCEDP) recipient identifier. BCEDP offers benefits to uninsured and underinsured women, 40 years and older, whose household income is at or below 200 percent of the federal poverty level. BCEDP offers reimbursement for screening, diagnostic and case management services. Please note: BCEDP and Medi-Cal are separate programs, but BCEDP is using the Medi-Cal billing process (with few exceptions).
9C	None	No	EXPANDED ACCESS TO PRIMARY CARE
9D	No Dental	No	CCS Only Child Enrolled in a Health Care Plan
9G	None		General Assistance/General Relief (County Only tracking)
9H	HF services only (no Medi-Cal)	N/A	The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 250 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.
9J	GHPP	No	Genetically Handicapped Person's Program (GHPP)-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	California Children's Services (CCS)-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9M	CCS Medical Therapy Program only	No	Eligible for CCS Medical Therapy Program services only.
9N	CCS Case Management	No	Medi-Cal recipient with CCS-eligible medical condition. Eligible for CCS case management of Medi-Cal benefits.
9R	CCS	No	CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management). The child's county of residence has no cost sharing for the child's CCS services.

Aid Code	Benefits	SOC	Program/Description
9T	Full Scope	No	HF adults linked by a child who is eligible for no Share of Cost Medi-Cal or HF.
9U	CCS	NO	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management). The child's county of residence has county cost sharing for the child's CCS services.
9X	None	No	COUNTY ONLY - FOSTER CARE
90	None	No	Unknown Aid Category
91	None	No	Unknown Aid Category
92	None	No	Unknown Aid Category
93	None	No	Unknown Aid Category
94	CHDP	No	CHDP
95	None	No	Unknown Aid Category
96	None	No	Unknown Aid Category
97	Limited Scope	No	Generic-Limited Scope
98	Restricted to pregnancy and emergency services	No	Generic Pregnancy/Emergency
99	Full Scope	No	Aid Code 99 – Generic-Full Scope
C1	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged - Medically Needy.
C2	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged - Medically Needy, SOC.
C3	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind - Medically Needy.

Aid Code	Benefits	SOC	Program/Description
C4	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind - Medically Needy, SOC.
C5	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC - Medically Needy.
C6	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC - Medically Needy SOC.
C7	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled - Medically Needy.
C8	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled - Medically Needy, SOC.
C9	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI - Child. Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
D1	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI - Child SOC. Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.

Aid Code	Benefits	SOC	Program/Description
D2	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged - Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D3	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged - Long Term Care (LTC), SOC. Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).

Aid Code	Benefits	SOC	Program/Description
D4	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind - Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D5	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind - Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D6	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled - Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).

Aid Code	Benefits	SOC	Program/Description
D7	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled - Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D8	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens - Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI - Confirmed Pregnancy. Covers persons aged 21 years or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent.
D9	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens - Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI - Confirmed Pregnancy SOC. Covers persons aged 21 or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
E1	Restricted to Pregnancy Related Services	No	MC-HF-Bridge Limited Scope No SOC
E2	Full Scope	No	ACA 2101 (f) Citizen/Lawful Age 0-19 No Premium
E4	Emergency/ Pregnancy	No	ACA 2101 (f) Undocumented Age 0-19 No Premium
E5	Full Scope	No	ACA 2101 (f) Citizen/Lawful Age 1-19 With Premium
E6	Full Scope	No	AIM Infants>213% FPL up to and including 266% FPL

Aid Code	Benefits	SOC	Program/Description
E7	Full Scope	No	AIM-Linked Infant>250% to and incl 300% w premium
E8	Full Scope	No	Accelerated Enrollment Medical Access Infant Program Newborn Gateway Linked Infant
F0	None	No	County HCCI Existing
F1	None	No	State Inmate No SOC-HOSP Inpatient Services
F2	None	No	Undoc State Inmate NSOC ESO/Preg- HOSP Inpatient SVC
F3	None	No	County Inmates No SOC-Hospital Inpatient Services
F4	None	No	Undoc Co Inmate No SOC ESO/Preg-HOSP Inpatient SVC
F9	None	No	County HCCI New
G0	Full Scope	No	Full Scope no SOC; State medically paroled adults
G1	None	No	Full Scope no SOC; State medically paroled adults
G2	None	No	Medi-Cal No SOC St Juvenile Inmate Undoc Emerg/Preg
G3	None	No	County Inmates SOC-Hospital Inpatient Services
G4	None	No	Inmate Undoc SOC INPHSPPRESO
G5	None	No	Limited Medi-Cal No SOC County Juvenile Inmate
G6	None	No	Medi-Cal No SOC Cty Juvenile Inmate Undoc Emerg/Preg
G7	None	No	Limited Medi-Cal SOC County Juvenile Inmates
G8	None	No	Medi-Cal No SOC Cty Juvenile Inmate Undoc Emerg/Preg.
G9	None		Medi-Cal State Inmate Program (MSIP)
H0	Full Scope	No	Hospital PE 6-19 above 108% up to 266% FPL
H1	Full Scope	No	Medi-Cal Targeted Low Income FPL for Infants
H2	Full Scope	No	Medi-Cal Targeted Low Income FPL Child 1-6 133-150%
H3	Full Scope	No	Medi-Cal Targeted Low Income FPL Child 1-6 150-250% Prem

Aid Code	Benefits	SOC	Program/Description
H4	Full Scope	No	MC Targeted Low Income FPL Child 6-19 100-150%
H5	Full Scope	No	MC Targeted Low Income FPL Child 6-19 150-250% Prem
H6	Full Scope	No	Hospital PE Infants 0-1 over 208% up to 266% FPL
H7	Full Scope	No	Hospital PE Child 1-6, at or below 142% FPL
H8	Full Scope	No	Hospital PE Child 6-19, at or below 108% FPL
H9	Full Scope	No	Hospital PE Child 1-6 above 142-266% FPL
IE	None	No	INELIGIBLE FOR DENTAL BENEFITS
J1	Full Scope	No	Full-scope No SOC County Med Probation/Comp Release
J2	Full Scope	Yes	Full-scope SOC County Medical Probation
J3	Emergency/ Pregnancy	No	Restricted No SOC County Medical Probation
J4	Emergency/ Pregnancy	Yes	Restricted SOC County Medical Probation
J5	Full Scope	Yes/ No	FS LTC Aged No SOC/SOC County Med Prob/Comp Release
J6	Emergency/ Pregnancy	Yes/ No	RS LTC Aged No SOC/SOC County Med Prob/Comp Release
J7	Full Scope	Yes/ No	FS LTC Dsbl No SOC/SOC County Med Prob/Comp Release
J8	Emergency/ Pregnancy	Yes/ No	RS LTC Dsbl No SOC/SOC County Med Prob/Comp Release
K1	Full Scope	No	Single Parent Safety Net & Drug/Fleeing Felon Family
K2	None		Medi-Cal State Inmate Program (MSIP)
K3	None		Medi-Cal State Inmate Program (MSIP)
K4	None		Medi-Cal State Inmate Program (MSIP)
K6	None		Medi-Cal State Inmate Program (MSIP)
K6	Full Scope	No	County Comp Release MAGI Adult 19-64 FPL 128-138 Citizen

Aid Code	Benefits	SOC	Program/Description
K7	Limited	No	County Comp Release MAGI Adult 19-64 FPL 128-138 Undoc
K8	Full Scope	No	County Comp Release MAGI Adult 19-64 FPL < 128 Citizen
K9	Limited	No	County Comp Release MAGI Adult 19-64 FPL < 128 Undoc
L1	Full Scope	No	LIHP/MCE transition to Medi-Cal Age 19-64, at or below 138% FPL
L6	Full Scope	No	Disabled/Blind 19 through to 65 at or below 128% FPL Citizen
L7	Limited	No	Disabled/Blind 19 up to 65 at or below 128% FPL undocumented
L8	Limited	No	T19 Pregnant Woman Wrap > 138% through 213%
L9	Full Scope	No	T 19 Newly Qualified Immigrants Wrap 0% - 138%
M1	Full Scope	No	Title XIX. Adults aged 19 to 64. Provides full-scope, no-cost Medi-Cal coverage to adults with income up to 138 percent of the FPL.
M2	Emergency/ Pregnancy	No	Adult 19 to 65 at or below 138% FPL Citiz/Lawful
M3	Full Scope	No	Parents/Caretaker Relative Citizens under 109% FPL
M4	Emergency/ Pregnancy	No	Parents/Caretaker Relative Undoc under 109% FPL
M5	Full Scope	No	Expansion Child 6-19 yrs 108-133% FPL Citizens
M6	Emergency/ Pregnancy	No	Expansion Child 6-19 yrs 108-133% FPL Undoc
M7	Full Scope	No	Pregnant Women under 60% FPL Citizen/Lawful
M8	Emergency/ Pregnancy	No	Pregnant Women under 60% FPL Undocumented
M9	Emergency/ Pregnancy	No	Pregnant Women 60-213% FPL Limited Citiz/Lawful
M0	Emergency/ Pregnancy	No	Pregnant Women 60-213% FPL Limited Scope Undoc
N0	None	No	County Inmate LIHP/MCE Transition to Medi-Cal

Aid Code	Benefits	SOC	Program/Description
N5	Non-Dental	No	Limited Scope Medi-Cal No SOC State Adult Inmate
N6	Non-Dental	No	Restricted Scope Medi-Cal No SOC State Adult Inmate
N7	Non-Dental	No	Limited Scope Medi-Cal No SOC Cty Adult Inmate
N8	Non-Dental	No	Restricted Scope Medi-Cal No SOC Cty Adult Inmate
N9	Full Scope	No	State Inmate LIHP/MCE transition to Medi-Cal
N0	Full Scope	No	County Inmate LIHP/MCE transition to Medi-Cal
P1	Full Scope	No	Children's Hospital Presumptive Eligibility
P2	Full Scope	No	Parent Caretaker Hospital Presumptive Eligibility
P3	Full Scope	No	Adult Hospital Presumptive Eligibility
P4	Emergency/ Pregnancy	No	Pregnancy Hospital Presumptive Eligibility
P5	Full Scope	No	ACA Child 6-19 Yrs 0-133% FPL Citizen
P6	Emergency/ Pregnancy	No	ACA Child 6-19 Yrs 0-133% FPL Undocumented
P7	Full Scope	No	ACA Child 1-6 Yrs 0-133% FPL Citizen
P8	Emergency/ Pregnancy	No	ACA Child 1-6 Yrs 0-133% FPL Undocumented
P9	Full Scope	No	ACA Infants 0-1 Yrs 0-200% FPL Citizen
P0	Emergency/ Pregnancy	No	ACA Infants 0-1 Yrs 0-200% FPL Undocumented
R1	Full Scope	No	CalWORKs TCVAP Trafficking Victims
R7	Non-Dental	No	WINS-TCF-Non-2-Parent
R8	Non-Dental	No	Work Incentive Nutritional Supplement-TCF2 Parent
R9	Non-Dental	No	Work Incentive Nutritional Supplement-TCFAP
RR	None	No	RESPONSIBLE RELATIVE
T1	Full Scope	No	Medi-Cal TLIC Infant Undoc 201-250% FPL
T2	Full Scope	No	Medi-Cal TLIC Ages 6-19 Citizen 151-250% FPL Prem
T3	Full Scope	No	Medi-Cal TLIC Ages 6-19 Citizen 134-150% FPL

Aid Code	Benefits	SOC	Program/Description
T4	Full Scope	No	Medi-Cal TLIC Ages 1-6 Citizen 151-250% FPL Prem
T5	Full Scope	No	Medi-Cal TLIC Ages 1-6 Citizen 134-150% FPL
T6	Emergency/ Pregnancy	No	Medi-Cal TLIC Infant Citizen 201-250% FPL
T7	Emergency/ Pregnancy	No	Medi-Cal TLIC Ages 6-19 Undoc 151-250% FPL Prem
T8	Emergency/ Pregnancy	No	Medi-Cal TLIC Ages 6-19 Undoc 134-150% FPL
T9	Emergency/ Pregnancy	No	Medi-Cal TLIC Ages 1-6 Undoc 151-250% FPL Prem
T0	Emergency/ Pregnancy	No	Medi-Cal TLIC Ages 1-6 Undoc 134-150% FPL Prem
V2	No Dental	No	PE for COVID-19 Diagnostic Testing, Testing-Related, and Treatment Services Only Limited Scope. There are no age, income, or resource limits. Satisfactory immigration status is not required.
X1	Non-Dental	No	Covered CA-Subsidized Coverage (250-400 FPL)
X2	Non-Dental	No	Covered California-Subsidized Cov 100-150 FPL)
X3	Non-Dental	No	Covered CA-Subsidized Coverage 151-200 FPL)
X4	Non-Dental	No	Covered CA-Subsidized Coverage 201-250 FPL)
X5	Non-Dental	No	Covered CA-Cost Sharing Waiver (100-300 FPL)
X6	Non-Dental	No	Covered CA-AI/AN CSR Only No Income Test
X7	Non-Dental	No	Covered CA-Unsubsidized Coverage (Above 400 FPL)
X8	Non-Dental	No	Covered CA-Lawful Present/MC ineligible <100% FPL
X9	Non-Dental	No	Covered CA-Narrow Bridge Program 200% FPL