Section 11 - Glossary

Effective May 1, 2022, Current Dental Terminology 2022 (CDT 22) was implemented which created changes to the Federally Required Adult Dental Services (FRADS), Pregnancy, Omnibus Budget Reconciliation Act (OBRA) member emergency, and Member Cap procedures.

Adjudication	A term that refers to the final resolution of a document in the Medi-Cal Dental claims processing system.
Adjudication Reason Code	A code specific to a claim service line reflecting the reason for modification or denial.
Amount Billed	The amount the provider has billed for each claim line.
Arch Integrity	There is arch integrity when there are sufficient proximate natural teeth in a restorable condition which would afford the opposing arch adequate or satisfactory occlusion for masticatory function.
Asynchronous Store and Forward	The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. Photographs taken by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan. Source: Business and Professions Code Division 2, Chapter 5, Article 12, Section 2290.5 (a)(6)
Attachments	Radiographs, photographs, or other documentation submitted with a claim, TAR or NOA.
Automated Eligibility Verification System (AEVS)	The on-line system for verifying Medi-Cal patient eligibility for a given month of service.
Balance	Lack of posterior balanced occlusion is defined as follows: a. Five posterior permanent teeth are missing (excluding 3rd molars), or b. All four 1st and 2nd permanent molars are missing, or c. The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
Member	A person eligible to receive Medi-Cal benefits.
Benefit	Dental or medical health care services covered by the Medi-Cal program.

Benefits Identification Card (BIC)	A permanent plastic identification card issued to a person certified to receive Medi-Cal benefits. The card identifies the person by name and includes an identification number and signature. The back of the card contains a unique magnetic strip similar to that on a credit card, designed to be used with a special point-of-service device to access the Medi-Cal automated eligibility verification system, enabling the dental office to immediately confirm the patient's eligibility for Medi-Cal benefits at the time of service.
Billing Provider	The provider who bills or requests authorization for services on the treatment form.
Bounded Tooth Spaces	Edentulous spaces in the arch with at least one tooth on each side (mesial and distal).
California Children's Services (CCS)	CCS provides diagnostic and treatment services, medical case management, dental services, and physical and occupational therapy services. CCS only authorizes dental services if such services are necessary to treat the member's CCS-eligible condition. Examples of medical conditions of children who are CCS-eligible include cystic fibrosis, hemophilia, heart disease, cancer, traumatic injuries, handicapping malocclusion, cleft lip/palate, and craniofacial anomalies.
CalWORKs	California Work Opportunity and Responsibility to Kids Program (CalWORKs) is California's welfare reform program, implementation provisions of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
Child Health and Disability Prevention (CHDP)	The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. Source: http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx
Client Index Number (CIN)	A 10-digit Medi-Cal member identifier that appears on the Medi-Cal identification card.
Claim Inquiry Form (CIF)	The Claim Inquiry Form (CIF) is used by the provider to inquire about the status of a TAR or Claim or to request reevaluation of a modified or denied claim.
Claim Inquiry Response (CIR)	The CIR is a computer-generated form used to explain the status of the TAR or Claim.

Clinical Screening Dentist	A licensed dentist who reviews claims and Treatment Authorization Requests (TARs) at the request of Medi-Cal Dental and provides clinical evaluations as to their merits.
Clinical Screening Reports	Reports submitted by Clinical Screening Dentists who participate in the Medi-Cal dental clinical screening network.
Contiguous Teeth	Teeth that are touching or adjacent to each other
Correspondence Reference Number (CRN)	An 11-digit number assigned to each incoming CIF or correspondence that identifies it throughout the processing system.
County Medical Services Program (CMSP)	The County Medical Services Program (CMSP) is a unique county/state partnership formed to provide for the medical and dental care needs of individuals 21-64, residing in California's 34 rural counties, now administered by Doral Dental Services.
Current Dental Terminology (CDT)	CDT is a reference manual published by the American Dental Association (ADA) that contains a number of useful components, including the Code on Dental Procedures and Nomenclature (Code), instructions for use of the Code, Questions and Answers, the ADA Dental Claim Form Completion Instructions, and Tooth Numbering Systems. The Code, published in the CDT reference manual, provides the dental profession with a standardized coding system to document and to communicate accurate information about dental treatment procedures and services to agencies involved in adjudicating insurance claims. CDT and the Code are used in dental offices and by the dental benefits industry for purposes of keeping patient records, reporting procedures on patients and processing and reporting of dental insurance claims, and in developing, marketing and administering dental benefit products. The Code is generally updated every two years. The updated code is published in a new edition of the CDT. Source: http://www.ada.org/ada/prod/catalog/cdt/index.asp On August 17, 2000 the Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure code from the version of the Code in effect on the date of service. The Code is also used on dental claims submitted on paper, and the ADA maintains a paper claim form whose data content reflects the HIPAA standard electronic dental claim. Source: http://ada.org/prof/resources/topics/cdt/index.asp
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

Document Control Number (DCN)	A unique 11-digit number assigned to each claim or TAR and used to identify the document throughout the processing system.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Services that allows Medi-Cal enrolled children and youth under age 21 to get preventive (screening) dental services and diagnostic and treatment services that are medically necessary to correct or ameliorate health conditions found during screening.
Explanation of Benefits (EOB)	A statement accompanying each payment to providers that itemizes the payments and explains the adjudication status of the claims.
Fair Hearing	See State Hearing.
Federally Required Adult Dental Services (FRADS)	Per Federal law requirements, the Federally Required Adult Dental Services (FRADS) are services by a dentist which a physician could reasonably provide.
Genetically Handicapped Person's Program (GHPP)	The GHPP is a State-funded program coordinating care and payment for selected dental services for persons 21 years of age or older with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.
Global	Treatment performed in conjunction with another procedure which is not payable separately.
Health Care Provider	A person who is licensed under this division.
Health Insurance Portability and Accountability Act (HIPAA)	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system will improve the use of electronic data interchange. Source: http://www.cms.hhs.gov/HIPAAGenInfo/
Interactive Telecommunications System	Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site health care provider.

IRCA/OBRA	Legislation for Medi-Cal Dental to pay for specific services provided for certain alien recipients who were previously ineligible for these benefits. The federal Immigration Reform and Control Act of 1986 (IRCA) and the Omnibus Budget Reconciliation Act of 1986, 1989 (OBRA) have extended limited or full-scope dental benefits for newly legalized amnesty aliens and/or undocumented aliens who are otherwise eligible for Medi-Cal but are not permanent U.S. residents under color of law. The services include emergency medical care, emergency dental care, and pregnancy-related services.
Julian Date	Claims received by Medi-Cal Dental are dated using the Julian calendar, in which a number is assigned to a day rather than using the month/day/year format. Julian calendar dates are 001 to 365 (366 for a leap year).
Manual of Criteria (MOC) for Medi-Cal Authorization (Dental Services)	The document that defines criteria per California Code of Regulations (CCR), Title 22, Section 51003, for the utilization of dental services under Medi-Cal Dental. It provides parameters to providers treating Medi-Cal members. It sets forth program benefits and clearly defines limitations, exclusions, and special documentation requirements.
Medicaid	A state-option medical assistance program that includes federal matching funds to states to implement a single comprehensive medical care program.
Medi-Cal	California's name for its Medicaid program.
Medi-Cal Benefits ID Card Number (BIC)	A 14-digit number for everyone EXCEPT CCS, whose number is 10 digits.
Medi-Cal Dental Provider Handbook (Handbook)	A reference guide prepared by Medi-Cal Dental and the Department and made available on the Medi-Cal Dental website to all providers enrolled in Medi-Cal Dental. It contains the criteria for dental services; program benefits and policies; and instructions for completing forms used in the Medi-Cal Dental .
Medically Indigent (MI)	A person previously eligible for Medi-Cal benefits who was not eligible for such benefits under the Public Assistance or Medically Needy program. This means the MI individual did not meet the age criterion for eligibility (age 65 or older) even though he or she may have been deprived, disabled or in medical need. Most services provided under the adult portion of the MI program were 100 percent State funded; some MI individuals were required to share in the cost of services provided them.

National Provider Identifier (NPI) Number	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. Covered entities may invoke contingency plans after May 23, 2007, and guidance about contingency plans may be found in the Downloads section below. Source: http://www.cms.hhs.gov/NationalProvIdentStand/
Notice of Authorization (NOA)	A computer-generated form sent to providers in response to their request for authorization of services.
Originating Site	A site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.
Other Coverage	When a Medi-Cal recipient's dental services are also fully or partially covered under other state or federal dental care programs, or under other contractual or legal entitlements, e.g., a private group or individual indemnification program.
Period of Longevity	The period of longevity in dentistry is considered to be the length or duration of acceptable service.
Prepaid Health Plan (PHP)	An organized system of health care that provides one or more medical services to an enrolled population for a predetermined capitated rate paid in advance.
Prior Authorization	A request by a provider for Medi-Cal Dental to authorize services before they are performed. Providers receive a Notice of Authorization (NOA) from Medi-Cal Dental, which they use to bill for services after they are performed.
Procedure Code	A code number that identifies specific medical or dental services with allowed amounts listed on the Schedule of Maximum Allowances (SMA).
Provider	An individual dentist, Registered Dental Hygienist in an Alternative Practice (RDHAP), dental group, dental school or dental clinic enrolled in the Medi-Cal program to provide health care and/or dental services to Medi-Cal eligible.
Provider Master File (PMF)	The file in the Medi-Cal Dental automated system which contains a record of each provider or dental group enrolled in and certified to provide dental services under Medi-Cal Dental.

Recipient	A person who has received Medi-Cal benefits.
Rendering Provider	The dentist whose services are billed under the billing provider's name and billing provider number. The rendering provider can also be referred to as the "treating provider."
Resubmission Turnaround Document (RTD)	A computer-generated form that Medi-Cal Dental sends to the provider to request missing or additional information needed to complete processing of a claim, TAR, or NOA.
Schedule of Maximum Allowances (SMA)	A listing of procedure codes with descriptions and maximum amount allowed for reimbursement of services.
Share of Cost (SOC)	The dollar amount that some Medi-Cal recipients must pay or obligate toward medical services before being certified as eligible for Medi-Cal.
State Hearing	A State Hearing is a legal process that allows members to request a reevaluation of any denied or modified Treatment Authorization Request (TAR). It also allows a member or provider to request a reevaluation of a reimbursement case.
Surface	Refers to portions of teeth to be restored.
Teledentistry	The mode of delivering dental health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's dental health care while the patient is at the originating site and the health care provider is at a distant site.
Supernumerary Teeth (Hyperdontia)	Extra erupted or unerupted teeth that resemble teeth of normal shape
Third Party Liability	When a Medi-Cal dental service is also the object of an action involving tort liability of a third party, Worker's Compensation Award, or casualty insurance claim payment.
Title 22 (Division 3, of the California Code of Regulations [CCR])	Contains the rules and regulations governing the Medi-Cal program, and defines and clarifies the provisions of State statute, chiefly the Welfare and Institutions Code.
Tooth Code	A code that identifies each tooth by a number or letter.
Treating Provider	See definition of rendering provider found above.
Treatment Authorization Request (TAR)/ Claim	The form used by a provider when requesting authorization to perform a service or to receive payment for said service. TAR/Claim forms are required for certain services and under special circumstances.
Treatment Plan	A statement of the services to be performed for the patient. Dental history, clinical examination and diagnosis are used as the basis to arrive at a logical plan to eliminate or alleviate the patient's dental symptoms, problems and diseases, and prevent further degenerative changes.

Treatment Series	A treatment series means all care, treatment, or procedures provided to a patient by the individual practitioner.
UCR Fee	Usual, customary, and reasonable fee.
Welfare and Institutions (W & I) Code	The State of California code of law that includes Medi-Cal statutes and laws.