

**CALIFORNIA
MEDI-CAL DENTAL
PROGRAM**

**BASIC & EDI SEMINAR
PACKET**

Revised 6/20/12



Denti-Cal

California Medi-Cal Dental Program

Dear Denti-Cal Provider and Staff:

Welcome! This seminar has been designed for dental providers and office staff who participate in the California Medi Cal Dental Program known as Denti-Cal.

The material contained in the training packet has been prepared to help familiarize you with the Denti-Cal Programs' policies, procedures and billing requirements. You should also refer to the Denti-Cal Provider Handbook, located on the Denti-Cal website at www.denti-cal.ca.gov for additional information.

We hope that you will benefit from the information presented at today's seminar. If you have any questions, please call our provider toll-free line at (800)-423-0507.

Sincerely,

Arbie Melvin
Director, Customer Service
Medi-Cal Dental Program

INTRODUCTION

Delta Dental of California has administered the California Medi-Cal Dental Program since 1974.

This packet contains the information discussed in today's seminar regarding basic billing procedures and the use of forms. Please refer to the *Denti-Cal Provider Handbook* for detailed, step-by-step instructions on how to complete each form.

When discussing the Denti-Cal program, some terminology may be unfamiliar. The seminar packet contains a glossary listing some of the terms mentioned in today's seminar.

THE DENTI-CAL WEBSITE

The screenshot shows the homepage of the Denti-Cal website. At the top, the title "The Denti-Cal Website" is displayed in a large serif font, with the URL "www.denti-cal.ca.gov" below it in a blue sans-serif font. The website header includes the "CA.GOV Department of Health Care Services" logo and a navigation menu with links for "Providers", "Beneficiaries", "Outreach", "Publications", "HIPAA", "NPI", "Managed Care", and "Statutes and Regulations". Below the header, there is a "Denti-Cal" section with a brief description of the program. To the left, a "MOST POPULAR LINKS" sidebar lists various resources like "Find a Medi-Cal Dentist" and "Provider Seminars". Below that is a "RELATED LINKS" section. On the right, a "WHAT'S NEW" section lists recent updates, and an "IMPORTANT REMINDERS" section lists key dates and events. Five blue callout boxes with red arrows point to specific areas: "Providers" points to the navigation menu; "Beneficiaries" points to the "Beneficiaries" link; "Most Popular Links" points to the sidebar; "What's New" points to the "WHAT'S NEW" section; and "Important Reminders" points to the "IMPORTANT REMINDERS" section.

Program Overview



National Provider Identifier (NPI) Numbers

- **Obtain NPI numbers from *National Plan & Provider Enumeration System (NPPES)*** <https://nppes.cms.hhs.gov>
 - **Type 1:** Health Care Providers who are individuals, including dentists & hygienists, & sole proprietorships, regardless of multiple service office locations
 - **Type 2:** Health Care Providers who are organizations, including dental practices, and/or individual dental practices who are incorporated
- **Dental offices many need both Type 1 and Type 2 NPI numbers**
 - Examples:
 - Individual dentists at one practice location where a Type 1 is needed for the dentist & a Type 2 for the practice if claims are submitted using the practice's name & Tax Identification Numbers (TINs)
 - Multiple dentists are at one practice location where a Type 1 is needed for the dentists & a Type 2 for the practice if claims are submitted using the practice's name & TIN
- **Report NPI numbers to Denti-Cal for both your billing and rendering provider numbers**
 - Through the Denti-Cal website: <http://www.denti-cal.ca.gov>
 - NPI Collection system or;
 - Hard copy Registration Form

Enrollment

- **Billing Provider Number** (*NPI for the business type*)
- **Personal Identification Number (PIN)**
- **Rendering Provider Number** (*NPI for the individual*)
- **Changes to the Practice**
- **Billing Intermediaries**
- **Denti-Cal Provider Handbook**
- **Denti-Cal Bulletins**



Important Telephone Numbers & Websites For Denti-Cal Providers



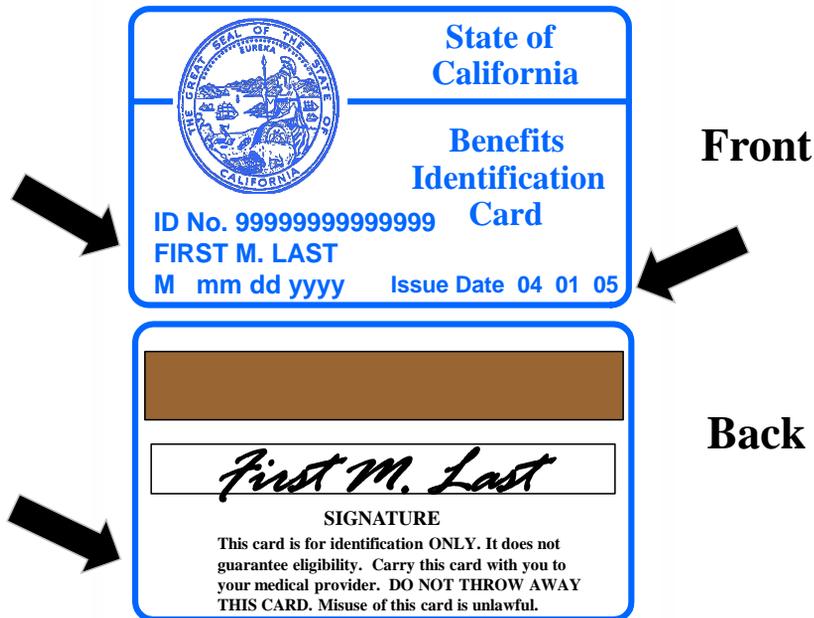
Provider Toll-Free Line	800-423-0507
Beneficiary Toll-Free Line	800-322-6384
A.E.V.S. (to verify beneficiary eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S. / Internet Help Desk	800-541-5555
Medi-Cal Website (to verify beneficiary eligibility)	www.medi-cal.ca.gov
Denti-Cal Website	www.denti-cal.ca.gov
EDI Technical Support	916-853-7373
Denti-Cal Forms (FAX #)	877-401-7534
CA Dept. Of Public Health	http://hfcis.cdph.ca.gov/servicesandfacilities.aspx

Eligibility



- The County Dept. of Social Services *establishes* eligibility
- Information is transferred to the Dept. of Health Care Services (DCHS)
- Verify eligibility monthly
- Beneficiaries turning 21 years of age
- Eligibility Verification Confirmation Number (EVC)

The Medi-Cal Benefits Identification Card (BIC)



Eligibility



- The Medi-Cal program *verifies* eligibility
- 3 ways to verify eligibility thru the Point of Service (POS) Network
 1. Touch Tone Telephone (AEVS)
 2. Internet (www.medi-cal.ca.gov)
 3. POS Device
- POS/Internet access are *free* of charge
- Request a POS Network/Internet Agreement from the POS/Internet Help Desk or Medi-Cal website

Web Eligibility

Screen #1

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

Office of Governor Edmund G. Brown Jr. Visit his Website

FEATURED

- Billing Tips → CMC
- FAQs → Forms
- Medical Supplies → NCCI
- NPI → Provider Bulletins
- Provider Enrollment → Provider Manuals

NEWSROOM COMING SOON Newsroom Archives

- Navigating Medi-Cal and Specialty Programs Chart Now Available
- Sales and Use Tax Decreased
- Extended Continuity of Care for SPOs Transitioning to Mandatory Managed Care
- Public Comment Forum: Hearing Aids Reimbursement Policy Change
- Implementation of HPAAs X12N 5010/NCPDP D 0 & 1.2 Transactions Delayed
- Implementation of HPAAs X12N 5010/NCPDP D 0 & 1.2 Transactions Delayed
- ACS Assumes Operations as the DHCS Fiscal Intermediary
- Walk-Up Claim Delivery Address Change
- ACS Strategy for Successful Adjudication of High-Volume Suspense Claims
- Pharmacy Reimbursement, Average Wholesale Price (AWP) Reporting
- Reimbursement Clarification for Prenatal Visits
- Claims Processing Guidance for Implementing ICD-10
- HPAA 5010 Companion Guides Released
- Medi-Cal Learning Portal (MLP) Frequently Asked Questions (FAQs)
- Provider Telecommunication Network Delay
- Possible Delay and Deferral of TARs
- HPAA 5010/NCPDP Frequently Asked Questions (FAQs)

RELATED

- DHCS
- CA Dept Public Health
- Medi-Cal Information for Individuals and Families

SYSTEM STATUS ALERT

Outreach & Education

Learning Tutorials

eTAR Features

Web Eligibility

Screen #2

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status | Login | Services Available | Enrollment Requirements

Home

Login to Medi-Cal

Please enter your User ID and Password. Click Submit when done.

Visit Transaction Enrollment Requirements for Medi-Cal.

Please enter your User ID:

Please enter your Password:

Note: The eTAR application requires logging in using an NPI number. All eTARs will be denied if logging in using a legacy number. Exemption: Legacy number usage is permitted only to Providers authorized by the Department of Health Care Services (DHCS).

Be careful to protect your user ID and password to prevent unauthorized use.

TRANSACTIONS

- User ID & Password Help
- Services Available

Contact Medi-Cal | Medi-Cal Site Help | Medi-Cal Site Map

Back to Top | Contact Us | Site Help | Site Map

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Web Eligibility

Screen #3

The screenshot shows the Medi-Cal website interface. At the top, there is a navigation bar with links for Home, Publications, Education, Programs, References, and Contact Medi-Cal. A search bar for Medi-Cal is located in the top right corner. The main content area is titled "Transaction Services" and includes a login status bar. Below this, there are two tabs: "Elig" and "Claims". The "Elig" tab is selected and circled in red. Under the "Elig" tab, there are several links: "Single Subscriber", "Multiple Subscribers", "Automated Ponder Services (PTN)", "Batch Internet Eligibility", "Medical Services Reservations (Medi-Services)", and "SOC (Spend Down) Transactions". A large grey arrow points from the "Elig" tab towards the "Single Subscriber" link. On the left side, there is a sidebar with the Medi-Cal logo and a "TRANSACTIONS" menu with links for Eligibility, Claims, and eLearning.

Web Eligibility

Screen #4

The screenshot shows the Medi-Cal website interface for the "Eligibility Verification" screen. The navigation bar and search bar are the same as in Screen #3. The main content area is titled "Eligibility Verification" and includes a login status bar. Below this, there is a form with several input fields: "Swipe Card:", "Subscriber ID:", "Subscriber Birth Date:", "Issue Date:", and "Service Date:". Each field has a red asterisk next to it, indicating it is a required field. Below the form, there are two buttons: "SUBMIT" and "CLEAR". Below the buttons, there is a link that says "Recall data from last transaction". At the bottom of the form, there is a note: "Click here for help on button usage. For help on fields, place the cursor in the desired field and click on the Help link on the left." A large grey arrow points from the "Elig" tab in Screen #3 towards the "Eligibility Verification" form. On the left side, there is a sidebar with the Medi-Cal logo and a "TRANSACTIONS" menu with links for Eligibility, Claims, and eLearning.

Web Eligibility

Screen #5

Eligibility Response

Eligibility transaction performed by provider: XXXXXXXXXX
on Monday, March 03, 2008 at 3:18:35 PM

TRANSACTIONS

- Eligibility
- Claims
- eLearning

Name: Last, First		
Recipient ID: 999999999999		
Date of Service: 10/10/2012	Date of Birth: 00/00/0000	Date of Issue: 10/01/2000
Primary Aid Code: 00	First Special Aid Code:	Second Special Aid Code:
Recipient County:	HIC Number:	
Primary Care Physician Phone#:	Scope of Coverage:	
Spend Down Amount (Share of Cost) Obligation:	Remaining Spend Down (SOC) Amount:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message:		

Additional Information

- Aid Code information may be found in the Denti-Cal Provider Handbook

- ✓ Type of Benefits
- ✓ SOC

Aid Codes

The following aid codes identify the types of services for which different Medi-Cal/CMSR/CCS/GHPF beneficiaries are eligible.

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	No	Refugee Cash Assistance (RCA). Includes unaccompanied children. Covers an eligible refugee during their first eight months in the United States. Unaccompanied children are not subject to the eight-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.
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.
0M	Full	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 45 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	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 Codes

- Not everyone receiving Medi-Cal has full-scope benefits

- Limited Services
- Restricted Services
 - Emergency only Services
 - Require an 'Emergency Certification Statement'

TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

ADAMS, JAMES: DDS 1234567891
 30 CENTER STREET, Box 333-3333
 ANYTOWN, CA 95814

ICD-9	ICD-10	DESCRIPTION OF SERVICE	DATE SERVICE PROVIDED	QUANTITY	UNIT	UNIT PRICE	AMOUNT	REASONABLE PROCEDURE ALL.
8		Extraction of erupted tooth	03.03.12	1	D7740	\$5.00	\$5.00	111111112

COMMENTS: #8 Pain & swelling - periapical abscess. John Smith, DDS

DATE: 03 03 12

Aid Codes

- *Emergency Services Only* aid codes (for OBRA beneficiaries) contain specific emergency procedures, regardless of age

- These procedures are *not* synonymous with the Federally Required Adult Dental Services (FRADS) procedures
- See Table 3 for the allowable procedures

Other Insurance Coverage

- Managed Care Plans

- Other Coverage



✓ Indemnity Plans

✓ Denti-Cal is always secondary carrier / Other coverage must be billed first

Share of Cost



Code	Description	Rate	Min
1454	Direct Day	1	1
1455	Direct Day	1	1
1454	Direct Day/Wk	2	1
1454	Direct Day	12	1
1455	Direct Day	1	1
1454	Direct Day	1	1
1450	Direct Day	1	1
0300	Direct Day	8	1
	20 Minutes		

- Is a pre-set amount determined by DHCS for an individual or family
- Any Health Care Services may be used
- Updating SOC
- Case Numbers
- Non Covered Services may be used to meet SOC

Updating SOC thru the POS Network

EXAMPLE: Patient share of cost is \$87.00

Description	Date of Service	Procedure Code	UCR Fee	Patient Portion
Examination	05/05/12	D0150	\$40.00	\$40.00
2 Bitewings	05/05/12	D0272	\$27.00	\$27.00
Prophy	05/05/12	D1120	\$60.00	\$20.00
Total			\$127.00	\$87.00

THEN: Submit a claim to Denti-Cal for all services provided.

Beneficiary Dental Cap

- \$1800.00 Calendar year maximum
 - ✦ Applies to adults only (*21 years & over*)
 - ✦ Children are exempt (*thru age 20*)
- *Exclusions to the Cap:*
 - ✦ Emergency dental services
 - ✦ Dentures
 - ✦ Maxillofacial & complex oral surgery
 - ✦ Services provided for long-term care aid codes
 - ✦ Services provided to residents of SNFs or ICFs
 - ✦ Federally mandated services (*including pregnancy-related services*)



ENROLLMENT

To receive payment for dental services performed for eligible Medi-Cal beneficiaries, prospective providers must apply and be approved by Denti-Cal to participate in the California Medi-Cal Dental Program. New providers are notified of their acceptance in writing after enrollment procedures are completed. **Prospective providers must not provide services to beneficiaries until they have received the confirmation letter.** The letter includes the provider's billing number, which is the National Provider Identifier (NPI) Number that the enrollee obtained from NPPES for their type of business. A second letter includes a personal identification number (PIN). The PIN will be used to access the provider's financial information, and to access beneficiary eligibility.

Denti-Cal maintains current and accurate records for each enrolled provider. Changes to enrollment status may require the completion of new enrollment forms. Changes may include but are not limited to; change of business name or address, or opening a new service office. Any changes must be sent to Denti-Cal within 35 days. To obtain an application for enrollment, report changes, or for information concerning enrollment status, please contact:

Denti-Cal
California Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-9978
(800) 423-0507

Enrollment forms are also available online at the Denti-Cal website, www.denti-cal.ca.gov.

RENDERING PROVIDERS

Rendering providers must be enrolled in the Denti-Cal program prior to rendering services to Denti-Cal beneficiaries. The rendering provider number will be the NPI number that the doctor obtained from NPPES based on their personal information.

BILLING INTERMEDIARIES

Denti-Cal will accept claims prepared and submitted by billing services acting on behalf of providers. A billing service must register with Denti-Cal by submitting a Billing Intermediary Registration Form. When submitting claims, their assigned registration number **must** be included. A provider using a billing intermediary must complete a Provider Billing Intermediary Notification Form and send it to Denti-Cal. Both forms may be obtained by calling (800) 423-0507, written correspondence, or from the Denti-Cal website. Ensure the billing intermediary knows where to find the Provider Handbook on the website.

Billing intermediaries must know and abide by the Medi-Cal and Denti-Cal regulations. The provider must ensure the billing intermediaries know these regulations prior to contracting with them. The provider is accountable for any incorrect or fraudulent billings submitted on their behalf.

THE DENTI-CAL PROVIDER HANDBOOK & BULLETINS

The *Denti-Cal Provider Handbook* and *Denti-Cal Bulletins* are available on the Denti-Cal website at www.denti-cal.ca.gov.

The *Denti-Cal Provider Handbook* has been developed to assist the provider and office staff with participation in the Denti-Cal program. It contains detailed information regarding the submission, processing and completion of all treatment forms and other related documents. The Handbook should be used frequently as a reference guide to obtain the most current criteria, policies and procedures of the California Medi-Cal Dental Program.

The Handbook is updated on a monthly and/or quarterly basis. As updates are made, they will be incorporated into the Provider Handbook. A copy of the updates will appear in the "What's New" section of the Denti-Cal website for printing purposes. The updates will include a cover letter with instructions on which pages or sections to replace.

The *Denti-Cal Bulletin* is published periodically to keep providers informed of the latest developments in the program. The "Provider Bulletins" section of the website should be checked frequently to insure the most current and up-to-date information regarding the Denti-Cal program is obtained.

MEDI-CAL BENEFICIARY IDENTIFICATION

Beneficiaries are required to sign their Benefits Identification Card (BIC) prior to presenting the card for services. This requirement does not apply to persons 17 years of age or younger, or to those who reside in a long-term care facility.

Verification of identification is required for beneficiaries who are unknown to the dental office *except*, when a beneficiary is 17 years of age or younger, is receiving emergency dental services, or resides in a long-term care facility. For all other beneficiaries, Denti-Cal providers must make a “good-faith” effort to verify identification before providing Medi-Cal dental services. A good-faith effort means matching the name and signature on the BIC against the signature on a valid photo ID or any other document which appears to validate and establish identity.

Medi-Cal beneficiaries who are unable to sign their name or make an “X” instead of a signature because of a disability are not required to sign their cards. Providers must still attempt to match the name on the BIC with an acceptable photo identification. If a provider does not attempt to identify a beneficiary and provides services to an ineligible beneficiary, payment for those services may be disallowed. Providers must verify eligibility every month for each beneficiary who presents a BIC, paper Immediate Need or Minor Consent card. A provider who declines to accept a Medi-Cal beneficiary must do so before accessing eligibility information with the exceptions listed in the Handbook. The State of California Department of Health Care Services (DHCS) will also review claims to determine providers who establish a pattern of providing services to ineligible beneficiaries or individuals other than the beneficiary indicated on the BIC.

If a provider suspects this type of fraud or abuse is occurring, he or she should report it immediately by calling the (800) 822-6222, Monday through Friday between 8:00 a.m. and 5:00 p.m.

The BIC is a permanent plastic card issued once. The front of the card contains the beneficiary’s ID number, name, birth date and issue date. The reverse side contains a magnetic strip and beneficiary signature area.

The BIC is *NOT* a verification of eligibility, but *DOES* contain the information to enable the provider to access eligibility.

Providers have several methods available to verify eligibility information. The options are:

1. Touch-tone telephone
2. Point of service (POS) network device
3. Internet access
4. Customized software

OPTIONS TO ACCESS THE POINT OF SERVICE (POS) NETWORK

The POS is set up to verify eligibility and perform Share of Cost (SOC) transactions. The network may be accessed through the following ways:

Touch-tone Telephone Access

With the use of an assigned PIN, all providers with a touch-tone telephone may access the Medi-Cal Automated Eligibility Verification System (AEVS). The automated system will provide eligibility and Share of Cost (SOC) information that is current and up-to-date. Please remember other information such as patient history or specific claim activity is available only through Denti-Cal. AEVS is accessible 22 hours a day, 7 days a week. The toll-free number to access AEVS is (800) 456-AEVS (2387).

Point of Service (POS) Network Device

Following guidelines established by the Department of Health Care Services (DHCS), all providers are eligible to receive a free POS device. This machine is similar to a credit card “swipe machine” used in department stores. The device contains a keypad with different function keys that will perform certain transactions. The BIC is guided through the machine, which reads the magnetic strip on the back of the card. If necessary, beneficiary information can also be entered manually. The dentist then has access to patient eligibility and SOC information by viewing the read-out on the screen. This information may also be printed by the POS device for a permanent record for the patient’s chart.

Internet Access

The Medi-Cal website on the internet at www.medi-cal.ca.gov allows providers to verify eligibility and update Share of Cost liability. This secure site is accessed by using the billing provider number and PIN

Custom Applications

Providers with large claim volume and extensive computer systems may require custom applications to allow their system to interface with the POS network. The technical specifications to develop the program are available at no charge. The same eligibility and SOC information will be available to those using this method.

ELIGIBILITY VERIFICATION CONFIRMATION (EVC)

If the beneficiary’s eligibility has been established for the month requested, an EVC number is received. This number should be recorded in the patient record. Please enter the EVC number in the field available on the Treatment Authorization Request (TAR)/Claim form, or in Box 23 on the Notice Of Authorization (NOA).

ELIMINATION OF OPTIONAL ADULT DENTAL SERVICES

Elimination of Optional Adult Dental Services

For beneficiaries not otherwise exempt

❖ **Exceptions:**

- Federally Required Adult Dental Services (FRADS)
- Specific services for pregnant beneficiaries
- Services for residents of Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), Intermediate Care Facility Developmentally Disabled (ICF-DD), Intermediate Care Facility Developmentally Disabled Habilitative (ICF-DDH), Intermediate Care Facility Developmentally Disabled Nursing (ICF-DDN)
- EPSDT eligible beneficiaries
- Dental services precedent to a covered medical service

FRADS (Table 1)

- Procedures are limited to those that may reasonably be provided by a physician
- **Benefits:**
 - ✓ Recementation of inlays, crowns, fixed partial dentures
 - ✓ Protective restorations
 - ✓ Extractions, anesthesia procedures & Maxillo-facial oral surgery procedures
 - ✓ Office visits for observation / palliative treatment
 - ✓ PAs & panoramic films should be billed on the *same* claim form as the qualifying FRADS procedure

Dental services for pregnant beneficiaries (Table 2)

- **Pregnancy related services & services for the treatment of other conditions that might complicate the pregnancy**
 - ✓ Comprehensive Oral Evaluation
 - ✓ Periodontal procedures
 - ✓ FRADS procedures
 - ✓ Prophy / Fluoride
 - ✓ *Bitewings*



Residents of Qualifying SNF, ICF, ICF-DD, ICF-DDH, ICF-DDN

- Benefits did not change for beneficiaries who reside in qualifying licensed facilities
- Services do not have to be provided in the facility to be payable
- Use the website to confirm the classification & licensing of a facility (*not all facilities qualify*):

<http://hfcis.cdph.ca.gov/servicesandfacilities.aspx>

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes are reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older.

***Please note:** The CDT 11-12 procedure codes marked with an asterisk (D0220, D0230, D0250, D0260, D0290, D0310, D0322 and D0330) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Proc. Code	Code Description
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical each additional film
D0250*	Extraoral - first film
D0260*	Extraoral - each additional film
D0290*	Posterior - anterior or lateral skull and facial bone survey film
D0310*	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330*	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay, onlay, or partial coverage restoration
D2920	Recement crown
D2940	Protective restoration
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis

Proc. Code	Code Description
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report
D6092	Recement implant/abutment supported crown

Table 1: FRADS *continued*

Proc. Code	Code Description
D6093	Recement implant/abutment supported fixed partial denture
D6100	Implant removal, by report
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm

Proc. Code	Code Description
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (including drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)

Table 1: FRADS *continued*

Proc. Code	Code Description
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy

Proc. Code	Code Description
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: debridement
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes
D7955	Repair of maxillofacial soft and hard tissue defect
D7971	Excision of pericoronal gingiva

Table 1: FRADS *continued*

Proc. Code	Code Description
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia

Proc. Code	Code Description
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral single administration
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 2: Allowable Procedure Codes for Pregnant Beneficiaries

Proc. Code	Code Description
D0120	Periodic oral evaluation (under age 21)
D0150	Comprehensive oral evaluation - new or established patient
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0270	Bitewing - single film
D0272	Bitewings - two films
D0274	Bitewings - four films
D1110	Prophylaxis - adult
D1120	Prophylaxis - child
D1203	Topical application of fluoride (prophylaxis not included) - child
D1204	Topical application of fluoride (prophylaxis not included) - adult
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

Proc. Code	Code Description
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant
D4260	Osseous surgery (including flap entry and closure) -four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) -one to three teeth, per quadrant
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant
D4920	Unscheduled dressing change (by someone other than treating dentist)
D9951	Occlusal adjustment - limited

Table 3: Emergency Services Only
Omnibus Budget Reconciliation Act (OBRA)

CDT 11-12 Code	CDT 11-12 Code Description
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0250	Extraoral - first film
D0260	Extraoral - each additional film
D0290	Posterior - anterior or lateral skull and facial bone survey film
D0330	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2920	Recement crown
D2940	Protective restoration
D2970	Temporary crown (fractured tooth)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6930	Recement fixed partial denture
D7111	Extraction, coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation

CDT 11-12 Code	CDT 11-12 Code Description
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue – soft
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	D7440
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone

Table 3: Emergency Services Only *continued*

CDT 11-12 Code	CDT 11-12 Code Description
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7980	Sialolithotomy
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Inhalation of nitrous oxide/anoxiolysis, analgesia
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call

CDT 11-12 Code	CDT 11-12 Code Description
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral drug, single administration
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report

~ Aid Code Reference Guide ~

(for Emergency/Pregnancy, Full Scope Aid Codes & other Exempt Groups)

	Emergency TABLE	FRADS TABLE 1	Pregnancy TABLE 2	Full Benefits
Under 21 - Full Scope aid code			X	X
21 & over - Full Scope aid code - Beneficiary is pregnant/postpartum		X	X	
21 & over - Full Scope aid code - Beneficiary <u>does not</u> reside in an ICF or SNF		X		
21 & over - Full Scope aid code - Beneficiary resides in an ICF or SNF				X
Under 21 - Emergency/Pregnancy aid code - Beneficiary is pregnant/postpartum	X		X	
Under 21 - Emergency/Pregnancy aid code - Beneficiary is <u>NOT</u> pregnant/postpartum	X			
21 & over - Emergency/Pregnancy aid code - Beneficiary is pregnant/postpartum	X		X	
21 & over - Emergency/Pregnancy aid code - Beneficiary is <u>NOT</u> pregnant/postpartum (regardless of where the beneficiary resides)	X			
* 21 & over - Emergency/Pregnancy aid code & Full Scope aid code - Beneficiary is pregnant/postpartum (Beneficiary <u>does not</u> reside in an ICF or SNF)	X	X	X	
* 21 & over - Emergency/Pregnancy aid code & Full Scope aid code - Beneficiary is <u>NOT</u> pregnant/postpartum (Beneficiary <u>does not</u> reside in an ICF or SNF)	X	X		

- **Each table has its own documentation requirements**
- **For Emergency-Only, & Pregnant/Postpartum Beneficiaries - see benefits in the Provider Handbook, *Section 4 - Treating Beneficiaries***

DDS Regional Center Consumers

- On January 1, 2012, Denti-Cal benefits were reinstated for Dept. of Developmental Services (DDS) Regional Center Consumers age 21 years and older
- All prior authorization/criteria guidelines apply
- Consumers are exempt from the 10% provider payment reduction (*with exceptions*)
- Consumers are exempt from the \$1800 annual dental cap

DDS Regional Center Consumers

- Verify Medi-Cal Eligibility (*call Medi-Cal*)
 - ✓ Understand Aid Codes, Other Coverage & SOC issues
- Verify DDS Consumers 21 years & older (*call Denti-Cal*)
 - ✓ Verify at time of service
- Understand the difference between DDS consumers & SNF/ICF beneficiaries
 - ✓ Prior Authorization guidelines
 - ✓ Scope of benefits may differ

Record Keeping Criteria for the Denti-Cal Program

The Surveillance and Utilization Review Subsystem (S/URS) department is responsible for overseeing and monitoring the California Medi-Cal Dental Program for suspected fraud, abuse, and poor quality of care.

The goal of the S/URS department is to ensure that providers and beneficiaries are in compliance with the criteria and regulations of the Denti-Cal program, and is governed by Title 22, the CA Code of Regulations. Refer to Section 8 (FRAUD) in the Denti-Cal Provider Handbook for further information.

**Surveillance & Utilization Review Subsystem
(S/URS)**

(Title 22, the California Code of Regulations)

Record Keeping Criteria for the Denti-Cal Program:

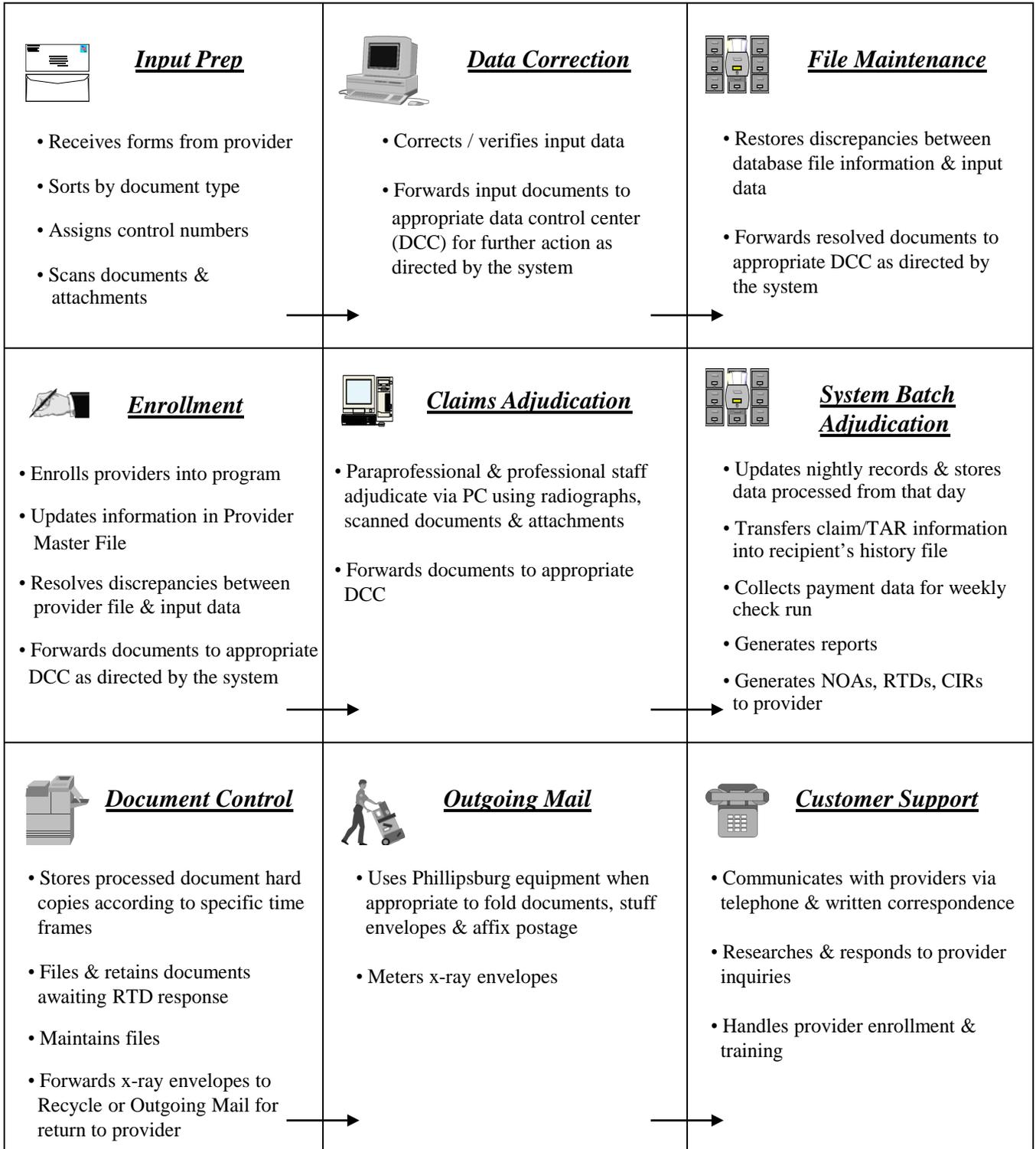
1. Complete beneficiary treatment records shall be retained for 3 years from the date the service was rendered and must be readily retrievable upon request.
2. Records shall include documentation supporting each procedure provided including, but not limited to:
 - Type and extent of services, and/or radiographs demonstrating and supporting the need for each procedure provided
 - Indicate the type of materials used, anesthetic type, dosage, vasoconstrictor and number of carpules used
 - Prophylaxis and fluoride treatments
 - Include the date and ID of the enrolled provider who preformed the treatment
3. Emergency services must have written documentation which includes, but is not limited to, the tooth/area, condition and specific treatment performed. The statement; 'An emergency existed' is NOT sufficient.

Provider Forms

- TAR / Claim Form
- NOA
- RTD
- EOB



Claims Processing Flow Chart



**California Medi-Cal Dental Program
BASIC TRAINING SEMINAR**

In administering the California Medi-Cal Dental Program, Denti-Cal’s primary function is to process Claims and Treatment Authorization Requests (TARs) submitted by providers for dental services performed for Medi-Cal beneficiaries. It is the intent of Denti-Cal to process documents as quickly and efficiently as possible. A description of the processing work flow is offered to promote a better understanding of the Denti-Cal automated claims system.

The TAR/Claim form and other related documents have been developed to simplify the billing process. An introductory packet of billing forms is mailed to all newly enrolled providers so they may begin participating in the Denti-Cal program. All billing forms are available from the Denti-Cal forms supplier at no charge to providers.

The *Denti-Cal Provider Handbook* contains detailed, step-by-step instructions for completing each of the Denti-Cal forms. The handbook also provides a handy checklist to help complete treatment forms accurately.

All incoming documents are received and sorted in the Denti-Cal mailroom. Claims and TARs are separated from other incoming documents and correspondence, and then assigned a Document Control Number (DCN). The DCN is a unique 11-digit number that identifies the treatment form throughout the processing system. By using the DCN, Denti-Cal can answer inquiries concerning the status of any treatment form received.

DCN = Document Control Number

CRN = Correspondence Reference Number

<i>12</i>	<i>160</i>	<i>1</i>	<i>12345</i>
<i>Year</i>	<i>Julian Date</i>	<i>Document Identifier</i>	<i>Sequential Number</i>

Document Identifier Code

1. Claim / TAR	2. RTD
3. CIF	4. MC177
5. Written Correspondence	6. Enrollment Forms
7. Telephone Inquiry	8. NOA



THE TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM FORM

The TAR/Claim form has been developed specifically for the Denti-Cal program. Providers can use this form to request authorization of treatment under the Denti-Cal program, or to submit for payment of completed, dated services. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist WHO PERFORMED THE SERVICE.

The dental office must accurately complete the form to insure proper and expeditious handling by Denti-Cal. Forms that are incomplete or inaccurately filled out may cause delays in processing and/or requests for additional information. Please insure the required information is typed or printed clearly. To submit the TAR/Claim form to Denti-Cal, follow these steps:

1. Check the form for completeness. Sign and date the form where appropriate.
2. Use two separate forms when requesting payment for dated services and prior authorization of treatment for other services. This will expedite reimbursement of allowable procedures.
3. When using forms DC-202 or DC-209, detach page 2 "*yellow page*" and retain for the patient's record. If using form DC-217, print an additional laser copy for the patient's record.
4. If required, include necessary radiographs/photos in the x-ray mailing envelopes provided by Denti-Cal. Remove the adhesive strip on the envelope, fold the flap and seal. Staple the x-ray envelope to the corresponding form.
5. If radiographs/photos are to be returned, affix a "Do Not Recycle" label to the *front* of the **addressed** x-ray envelope.
6. Mail the completed form(s) in the large pre-addressed mailing envelope (DC-206) that is provided to you free of charge. Up to 10 forms with attached x-ray envelopes may be mailed in a single document mailing envelope.
7. Mail the TAR/Claim forms to:

Denti-Cal
California Medi-Cal Dental Program
P.O. Box 15610
Sacramento, CA 95852-0610

After a claim has been processed, Denti-Cal will automatically recycle all radiographs unless the "Do Not Recycle" message and the provider's address are clearly visible on the front of the x-ray envelope. For this reason, it is important that the provider information is correct. The x-ray envelope is to be used for radiographs/photos only. DO NOT use the x-ray envelope for any other type of documentation other than radiographs/photos. More information can be found in Section 6: Forms of the Handbook.

DO NOT WRITE IN THIS AREA

12 266 1 00113

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507



TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.) Last, First		3. SEX M F x	4. PATIENT BIRTHDATE MO DAY YR mm dd yy	5. MEDI-CAL BENEFITS ID NUMBER 999999999999999
6. PATIENT ADDRESS Address			7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE Address		ZIP CODE 00000		8. REFERRING PROVIDER NUMBER
9. RADIOGRAPHS ATTACHED? CHECK IF YES X HOW MANY? 3	11. ACCIDENT/INJURY? CHECK IF YES YES EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE: CHECK IF YES YES	14. MEDICARE DENTAL COVERAGE: CHECK IF YES YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES YES
10. OTHER ATTACHMENTS? CHECK IF YES YES	12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) CHECK IF YES YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) CHECK IF YES YES	17. CCS CALIFORNIA CHILDREN SERVICES? CHECK IF YES YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? CHECK IF YES YES
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.) ADAMS, JAMES DDS		20. BILLING PROVIDER NUMBER 1234567891		
21. MAILING ADDRESS 30 CENTER STREET		TELEPHONE NUMBER (xxx) xxx-xxxx		
CITY, STATE ANYTOWN, CA		ZIP CODE 95814		
22. PLACE OF SERVICE X OFFICE HOME CLINIC SNF ICF HOSPITAL IN-PATIENT HOSPITAL OUT-PATIENT OTHER (PLEASE SPECIFY)		BIC Issue Date: 1/15/06		
		EVC #: 123456789A1		

EXAMINATION AND TREATMENT							
26. TOOTH#/LTR. ARCH. QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NO.
		1 Exam	09 10 12		D0150	25.00	9912345678
		2 4 Bitewings	09 10 12		D0274	20.00	9912345678
		3 Additional PA's	09 10 12	6	D0230	24.00	9912345678
8	MIF	4 Composite	09 10 12		D2332	150.00	9912345678
5	MOD	5 Amalgam	09 10 12		D2160	65.00	9912345678
16		6 Extraction	09 10 12		D7140	125.00	9912345678
		7					
		8					
		9					
		10					

34. COMMENTS	35. TOTAL FEE CHARGED	409.00
	36. PATIENT SHARE-OF-COST AMOUNT	
	37. OTHER COVERAGE AMOUNT	
	38. DATE BILLED	09 12 12

X Mary Smith 09 12 12
SIGNATURE DATE

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, MUST be attached to this form. The X-Ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.



TAR/CLAIM FORM
HELPFUL HINTS & REMINDERS

1. Use only the CDT 11-12 procedure codes. Be sure to use all four digits including the leading “D
2. Use the quantity column (field 30) when listing multiple procedures with the same procedure number.
3. When submitting the form for payment of dated services, be sure to include the rendering provider number in field 33.
4. Sign and date the form.
5. Staple any necessary attachments (e.g., operative reports, periodontal charts, etc.) to the form with one staple in the upper right or left corner. Do not place attachments in the x-ray envelope.
6. Use field 34 for any narrative documentation.
7. Continuous TAR/Claim forms and laser forms are not pre-imprinted by Denti-Cal. Enter your provider name, number and address exactly as it appears on your initial stock of forms.
8. ***If dated services are submitted on a request for authorization, they will not be paid until the authorized services are paid.***
9. Denti-Cal will consider payment for dated services at 100% of the Schedule of Maximum Allowances (SMA) if the form is received within six months of the date of service. If the form is received within seven to nine months of the date of service, 75% of the of the SMA will be considered for payment. If the claim is received within ten to twelve months of the date of service, 50% of the SMA will be considered for payment.
10. **REFER TO YOUR DENTI-CAL PROVIDER HANDBOOK FOR MORE DETAILED INFORMATION ABOUT SUBMITTING THE TAR/CLAIM FORM.**

THE NOTICE OF AUTHORIZATION (NOA) FORM

The NOA is a computer-generated form which Denti-Cal sends to the provider following final processing of a TAR. Denti-Cal will indicate on the NOA whether the requested services are allowed, modified, or disallowed. The NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

The NOA will be pre-printed by Denti-Cal with the following information:

- Authorized period of time (the 'From' and 'To' date)
- Beneficiary information
- Provider information
- Procedures allowed, modified, and/or disallowed
- Allowance
- Adjudication Reason Codes (A list of adjudication codes may be found in your *Denti-Cal Provider Handbook*.)

The NOA received by the dental office is printed with the same information that was submitted on the original TAR. **Please be sure to verify that the printed information is correct prior to completing the form and returning it to Denti-Cal.**

Authorizations are valid for 180 days. Once the services have been performed, complete the appropriate shaded areas on the NOA, sign and date, and submit one copy to Denti-Cal for payment. Retain the other copy for the patient's record.

Services not requiring prior authorization may be added to the NOA. However, any required radiographs and/or documentation for those procedures must be included.

Denti-Cal will consider payment of 100% of the Schedule of Maximum Allowances (SMA), for services rendered if the NOA form is received within six months of the FINAL date of service. If the NOA is received within seven to nine months of the FINAL date of service, 75% of the SMA will be considered for payment. And, if the NOA is received within ten to twelve months of the FINAL date of service, 50% of the SMA will be considered for payment.

DO NOT WRITE IN THESE AREAS

12318100124

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800- 423- 0507



NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

RE-EVALUATION IS REQUESTED YES

FROM: 11/14/12
TO: 05/13/13

PAGE ____ OF ____



1. BENEFICIARY NAME (LAST, FIRST, M.I.) Last, First			2. GENDER M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. BENEFICIARY BIRTHDATE MO DAY YR mm dd yy			5. BENEFICIARY MEDI-CAL I.D. NO. 99999999999999		
9. RADIOGRAPHS ATTACHED? CHECK IF YES <input type="checkbox"/> HOW MANY? _____		10. OTHER ATTACHMENTS? CHECK IF YES <input type="checkbox"/>		11. ACCIDENT / INJURY? CHECK IF YES <input type="checkbox"/> EMPLOYMENT RELATED? CHECK IF YES <input type="checkbox"/>		13. OTHER DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/>		16. CHDP CHECK IF YES <input type="checkbox"/>		7. BENEFICIARY DENTAL RECORD NO.	

Adams, James, DDS **1234567891**
30 Center Street **(xxx) xxx-xxxx**
Anytown, CA **95814**

23. BIC Issue Date: _____
EVC #: _____

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SUR. FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
	3		1 Root Canal Therapy	XXXXX		D3320	500.00	.00	R270	
	3		2 Root Canal Therapy			D3330	500.00	331.00	S270	
	3	O	3 Amalgam			D2140	55.00	39.00	355C	
	9		4 Extraction - Erupted Tooth			D7140	50.00	41.00	355C	
	U		5 Partial Denture - Resin Base		01	D5211	400.00	250.00		
	LL		6 Scaling & Root Planing	XXXXX		D4341	50.00	.00	074B	
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED	<ul style="list-style-type: none"> ADJUSTMENT CODES - SEE PROVIDER HANDBOOK AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY. AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS. USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED. 	35. TOTAL FEE CHARGED	1555.00
45. PROSTHESIS LINE ITEM		46. TOTAL ALLOWANCE	661.00

34. COMMENTS	36. BENEFICIARY SHARE-OF-COST AMOUNT	
	37. OTHER COVERAGE AMOUNT	
	38. DATE BILLED	

NOTICE OF AUTHORIZATION

- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. TREATMENT COMPLETED - PAYMENT REQUESTED
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM. DATE

SIGN ONE COPY AND SEND IT TO DENTI-CAL - RETAIN THE OTHER FOR YOUR RECORDS.

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARIE'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.



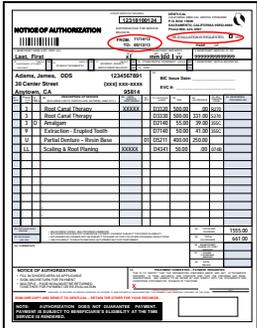
REEVALUATION REQUEST

Reevaluation of a modified or denied treatment plan may be requested. The reevaluation request must be received by Denti-Cal on or prior to the expiration date. To request reevaluation, follow these steps:

1. Check the box marked “*REEVALUATION REQUESTED*” in the upper right corner of the NOA.
2. **DO NOT SIGN THE NOA.**
3. Include new or additional documentation and enclose radiographs as necessary.
4. Return the NOA to:
Denti-Cal
California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609

After reevaluation, a new NOA will be sent to your office.

Reevaluation



- Do Not sign NOA
- Do submit radiographs & new / additional documentation
- NOA must be received on or before he 'expiration date'
- NOA may only be resubmitted '1 time'

RESUBMISSION TURNAROUND DOCUMENT (RTD)

The RTD is a computer-generated form sent to request missing or additional information needed to completely process the claim, TAR or NOA.

The RTD consists of two sections: Section “A” and Section “B”. The top portion “A” of the RTD indicates the associated DCN and lists the error(s) found on the original document. Section “A” also indicates the return due date. The provider has 45 days to respond to the RTD. Retain Section “A” for the office records. Section “B” indicates the associated DCN, lists the error(s) found on the original document and provides space to enter the requested information.

To ensure the RTD is properly processed, follow these steps:

1. Sign and date the RTD. If the RTD is returned unsigned, the requested information cannot be used to process the original claim, TAR or NOA.
2. Return all pages of a multi-page RTD in one envelope.
3. Return the RTD promptly. If the RTD is not received by Denti-Cal within the 45-day time limitation, Denti-Cal must deny the original claim, TAR or NOA.
4. Return the RTD to:

Denti-Cal
California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609

More information can be found in Section 6: Forms of the Handbook.

DIRECT DEPOSIT OF PAYMENTS

Denti-Cal offers the ability to have Denti-Cal payments transferred directly to a checking or savings account. Providers may request a Direct Deposit Enrollment Form by calling the Customer Service Toll-free line at (800) 423-0507, by accessing the Denti-Cal web site, or by writing to:

Denti-Cal
California Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-9978

When a Direct Deposit Enrollment Form is received, Denti-Cal, we will verify that the bank participates in electronic funds transfer. A zero-dollar test deposit will be sent through the bank to verify account information. A “zero” deposit to the provider's account for that payment date will appear on the Explanation of Benefits (EOB). This process usually requires three to four weeks to complete. In the interim, a paper check will be issued . Each time an electronic deposit is made, the EOB will include a statement confirming the amount of the deposit.

Direct Deposit

- ❖ Denti-Cal payments are deposited directly into a checking or savings account
- ❖ Complete a *Direct Deposit Enrollment Form*
- ❖ No more waiting for the mail service
- ❖ Notification of deposits will appear on the EOB



THE EXPLANATION OF BENEFITS (EOB)

The EOB is a computer-generated statement that accompanies each Denti-Cal payment. It lists all paid, modified and denied claims which have been processed during the payment cycle, as well as adjusted claims, and claims and TARs which have remained “in process” for more than 18 days. The EOB also shows non-claims-specified information, such as payable/receivable amounts, and levy deductions. EOBs are normally issued weekly.

Following is an explanation of each item shown on the sample EOB:

1. **The Beneficiary’s Information**: This line is preceded by an “B” for “Beneficiary.”
2. **Claim information for the listed beneficiary**: This line is preceded by a “C” for “Claim”.
3. **Provider Number**: The National Provider Identifier (NPI) number that was issued by NPPES to a provider for their type of business.
4. **Provider Name & Address**: The provider’s name & billing address.
5. **Check Number**: The number of the check issued with the EOB.
6. **Date**: The date the EOB was issued.
7. **Page Number**: The page number(s) of the EOB.
8. **Status Code Definition**: The list of each status code used to identify a claim line and explanation of what each code means.
9. **Beneficiary Name**: The name of the beneficiary; last name, first name and middle initial. Each beneficiary is listed individually.
10. **Medi-Cal ID Number**: The number issued to the beneficiary by Medi-Cal and shown on the BIC (only the first nine digits will appear on the EOB).
11. **Beneficiary ID**: The beneficiary’s ID number.
12. **Sex**: The sex of the beneficiary.
13. **Birth Date**: The beneficiary’s date of birth.
14. **Document Control Number**: The identifying number assigned to each claim received by Denti-Cal.

California Medi-Cal Dental Program
BASIC TRAINING SEMINAR

15. **Tooth Code**: The tooth number or letter, arch code or quadrant listed to help identify the procedure(s) reported on the EOB.
16. **Procedure Code**: The code listed on a claim line identifying each service performed. This code may differ from the procedure code submitted on the claim because of modification of the procedure by a Denti-Cal professional or paraprofessional to comply with the criteria manual and successfully process the claim.
17. **Date of Service**: The date the service was performed.
18. **Status**: Identifies the status of each claim line. (See item 8 for a list of status codes and their definitions.)
19. **Reason Code**: Explains why a claim line was either denied, modified, altered or paid at an amount other than billed.
20. **Amount Billed**: The amount billed for each claim line.
21. **Allowed Amount**: The amount allowed by Denti-Cal for each claim line. This amount is the lesser of the billed amount and maximum amount allowed by the SMA.
22. **Share of Cost**: The amount the beneficiary paid toward a Share of Cost.
23. **Other Coverage**: The amount paid by Medicare or any other insurance carrier.
24. **Amount Paid**: The total amount paid to a provider after any applicable deductions shown in item 22 and 23.
25. **Claims Specific**: The total amounts of all paid and adjusted claims listed on the EOB.
26. **Non-Claims Specific**: The total payable amounts, levy amounts and receivable amounts listed on the EOB, if applicable. This information is printed on the last page of the EOB.
27. **Check Amount**: The amount of the check that accompanies the EOB.

More information can be found in Section 6: Forms of the Handbook.

EXPLANATION OF BENEFITS

DENTI-CAL
 CALIFORNIA MEDI-CAL DENTAL PROGRAM
 P.O. BOX 15609, SACRAMENTO, CA 95852-0609



1 LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION
 2 LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

3 PROVIDER No **1234567899**

5 CHECK No **00596352**

4
Adams, James, DDS
30 Center Street
Anytown, CA 95814

6 **DATE: 08/15/12** 7 **PAGE NO. 3**
 of 3

8 STATUS CODE DEFINITION
 P = PAID
 D = DENIED
 A = ADJUSTED

PLEASE CALL (800) 423-0507
 FOR ANY QUESTIONS REGARDING THIS DOCUMENT

9 BENEFICIARY NAME 10 MEDI-CAL I.D. NO. 11 BENE ID 12 SEX 13 BIRTH DATE
 14 DOCUMENT CONTROL NO. 15 TOOTH CODE 16 PROC. CODE 17 DATE OF SERVICE 18 STATUS 19 REASON CODE 20 AMOUNT BILLED 21 ALLOWED AMOUNT 22 SHARE OF COST 23 OTHER COVERAGE 24 AMOUNT PAID

ADJUDICATED CLAIMS

B	LAST	FIRST		99999999D	99999999D	M	mm/dd/yy
C	12163108181	D0150	06/01/12	P	25.00	25.00	25.00
C		D0274	06/01/12	P	30.00	18.00	18.00
C		D0230	06/01/12	P	30.00	18.00	18.00
C		D1120	06/01/12	D	R019 47.00	.00	.00
C		D1110	06/01/12	P	S019 47.00	40.00	40.00
CLAIM TOTAL					132.00	101.00	101.00
**TOTAL ADJUDICATED CLAIMS					132.00	101.00	101.00

ADJUSTMENT CLAIMS

B	LAST	FIRST		99999999D	99999999D	F	mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED							
C	12168101357	15	D7210	06/10/12	A	266B - 95.00	- .00
C		14	D2140	06/10/12	A	- 50.00	- 39.00
C		13	D2140	06/10/12	A	- 50.00	- 39.00
CLAIM TOTAL					- 195.00	- 78.00	- 78.00
B	LAST	FIRST		99999999D	99999999D	F	mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED							
C	12168101357	15	D7210	06/10/12	P	95.00	85.00
C		14	D2140	06/10/12	P	50.00	39.00
C		13	D2140	06/10/12	P	50.00	39.00
CLAIM TOTAL					195.00	163.00	163.00
*TOTAL ADJUSTED CLAIMS					00.00	85.00	85.00
**PROVIDER CLAIMS TOTAL					132.00	186.00	186.00

25 CLAIMS SPECIFIC		26 NON CLAIMS SPECIFIC		27	
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00				186.00

EXPLANATION OF BENEFITS

DENTI-CAL

CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609



LINES PRECEDED BY "R" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No 1234567899

CHECK
No 00596352

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 08/15/12 PAGE NO. 3
of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STATUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID	
BENEFICIARY NAME				MEDI-CAL I.D. NO.	BENE ID	SEX	BIRTH DATE				



DOCUMENTS IN-PROCESS

LAST NAME	FIRST NAME	MEDI-CAL ID	BENE ID	DOB	DCN	AMT BILLED	*CODE
LAST	FIRST	99999999D	99999999D	mm/dd/yy	12168108150	567.00	C IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	12169103850	423.00	T CS
LAST	FIRST	99999999A	99999999A	mm/dd/yy	12175100684	112.00	C IR
TOTAL DOCUMENTS IN-PROCESS			3	TOTAL BILLED		1102.00	

* THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR REEVALUATION

- DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
- IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR XRAYS/ATTACHMENTS WAS SENT TO PROVIDER)
- RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
- PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
- PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
- CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
- SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN ON 09/10/12 FROM 8:30 AM TO 11:30 AM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON 09/11/12 FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN ON 10/15/12 FROM 8:30 AM TO 3:30 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

Provider Inquiries

- Claim Inquiry Forms



THE CLAIM INQUIRY FORM (CIF)

Submitting a CIF enables Denti-Cal to give an automated, fast response to an inquiry. The dental office should use the CIF for two reasons:

- Inquire about the status of a TAR or Claim
 - Request reevaluation of a modified or denied claim or NOA for payment.
- Denti-Cal will respond to a CIF with a Claim Inquiry Response (CIR).

CIF TRACER: Is used to request the *status* of a claim or TAR.

Providers should wait one month before submitting a CIF Tracer to allow enough time for the document to be processed. If after one month, the claim or TAR has not been processed or has not appeared in the *Documents In Process* section of the EOB, a CIF Tracer should be submitted.

CLAIM REEVALUATION: Is used to request the *reevaluation* of a modified or denied claim or NOA.

If a provider wishes to have a processed claim or NOA that has appeared on the EOB reevaluated, a CIF Reevaluation should be submitted. The CIF must be submitted within 6 months of the date on the EOB. **DO NOT** re-bill on a claim form.

To submit a CIF to Denti-Cal, follow these steps:

1. Use a separate CIF for each inquiry.
2. Check only one inquiry reason box on each CIF.
3. Complete all applicable areas.
4. Sign and date.
5. Attach all related radiographs/photos.
6. **DO NOT USE THE CIF TO REQUEST A FIRST LEVEL APPEAL.**
7. Mail to:

Denti-Cal
California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0610

Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by telephone or written correspondence. Prior to submitting a CIF, please contact the telephone service center (TSC) at (800) 423-0507 with any inquiries.

All radiographs/photos submitted with a CIF must be enclosed in an x-ray envelope (DC-214A or DC-214B). If radiographs are to be returned to the dental office, the “Do Not Recycle” message and the provider's address must be clearly visible on the front of the x-ray envelope. Be sure the x-ray envelope is attached to the back of the CIF. More information can be found in Section 6: Forms of the Handbook.

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CI:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call DENTI-CAL

DENTI-CAL
CALIFORNIA MEDICAL DENTAL PROGRAM
P.O. BOX 15669
SACRAMENTO, CALIFORNIA 95852-0669
Phone 800-423-0507



BILLING ACCOUNT NUMBER Adams, James DDS	1234567899
MALPRACTICE NUMBER 30 Center Street	(XXX) XXX-XXXX
CITY, STATE Anytown, CA	ZIP CODE 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI) Last, First		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
PATIENT MEDICAL I.D. NUMBER 99999999999999	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED 2/13/12
INQUIRY REASON - CHECK ONLY ONE BOX		
CLAIM/TAR TRACER ONLY Please advise status of: <input checked="" type="checkbox"/> Claim for Payment. Attach a copy of form Date of Service 2/11/12 <input type="checkbox"/> Treatment Authorization Request (TAR). Attach a copy of form.		CLAIM RE-EVALUATION ONLY <input type="checkbox"/> Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.
REMARKS (Corrections or Additional information) <i>Please research claim for D.O.S. 2/11/12- we have no record of payment. Thank you</i>		
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM. X <u><i>Mary Jones</i></u> _____ DATE <u>3/15/12</u> SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.		FOR DENTI-CAL USE ONLY OPER. I.D. _____ ACTION CODE _____

CORRESPONDENCE REFERENCE NUMBER * FOR DENTI-CAL USE ONLY

12084300132

CLAIM INQUIRY RESPONSE

**Adams, James,
30 Center Street
Anytown, CA**

DDS

**1234567899
(XXX) XXX-XXXX
95814**

DENTI-CAL
MEDICAL DENTAL PROGRAM
P.O. BOX 15669
SACRAMENTO, CALIFORNIA 95852
Phone (800) 423-0507

PATIENT NAME
Last, First
PATIENT MEDICAL I.D. NO.
99999999D

DOCUMENT CONTROL NO.

DATE BILLED
02/13/12

IN RESPONSE TO YOUR DENTI-CAL INQUIRY

STATUS CODE

EXPLANATION

01

CLAIM NEVER RECEIVED: PLEASE RESUBMIT

ADDITIONAL EXPLANATION

BY: **TAW**

DATE: **04/03/12**

RESPONSES TO CIF INQUIRIES

The Claim Inquiry Response (CIR) (Claim/TAR Tracer)

After resolving your CIF Tracer inquiry, Denti-Cal will send your office a computer-generated CIR. The CIR explains the status of your claim or TAR. It contains the same information as the original document submitted by your office and will identify the patient's name, Medi-Cal ID number, dental record number (if applicable), DCN of the original document, and the date services were billed. The middle section of the form under the heading "In Response to your Denti-Cal Inquiry" contains a status code and a printed explanation of the code.

The Explanation of Benefits (EOB) (Claim Reevaluation)

After processing your CIF for claim reevaluation, the response will be indicated on the EOB under "Adjustment Claims."

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call DENTI-CAL

DENTI-CAL
 CALIFORNIA MEDI-CAL DENTAL PROGRAM
 P.O. BOX 15609
 SACRAMENTO, CALIFORNIA 95852-0609
 Phone 800-423-0507



BILLING PROVIDER NAME Adams, James DDS		MEDI-CAL PROVIDER NUMBER 1234567899
MAILING ADDRESS 30 Center Street		TELEPHONE NUMBER (XXX) XXX-XXXX
CITY, STATE Anytown, CA	ZIP CODE 95814	

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI) Last, First		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION) 12168101357
PATIENT MEDI-CAL I.D. NUMBER 9999999999999999	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED

INQUIRY REASON - CHECK ONLY ONE BOX

<p>CLAIM/TAR TRACER ONLY</p> <p>Please advise status of:</p> <p><input type="checkbox"/> Claim for Payment. Attach a copy of form Date of Service _____.</p> <p><input type="checkbox"/> Treatment Authorization Request (TAR). Attach a copy of form.</p>	<p>CLAIM RE-EVALUATION ONLY</p> <p><input checked="" type="checkbox"/> Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.</p>
---	--

REMARKS (Corrections or Additional information)

Please re-evaluate #15 procedure D7210 - X-ray enclosed.

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X Mary Jones 7/25/12
 SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR DENTI-CAL USE ONLY

OPER. I.D. _____

ACTION CODE _____



Provider Appeals Process

- First Level Appeals



THE PROVIDER APPEALS PROCESS

A provider may request a First Level Appeal by submitting a formal written grievance to Denti-Cal. Submission of a CIF is not required prior to the First Level Appeal.

The First Level Appeal procedure is as follows:

1. The appeal must be submitted in writing to Denti-Cal within 90 days of the action precipitating the complaint or grievance. *Do not use a CIF for this purpose.*
2. The letter must specifically indicate a request for a First Level Appeal.
3. The appeal must clearly identify the claim or TAR in question and describe the disputed action.
4. Keep a copy of all documents related to the appeal.
5. Denti-Cal will acknowledge the appeal request with in 21 calendar days of receipt.
6. Direct first level appeals to:

Denti-Cal
Attn: Provider First Level Appeals
PO Box 13898
Sacramento, CA 95853-4898

Denti-Cal staff (including professional review if necessary) will review the appeal and respond in writing if the denial is upheld.

JUDICIAL REMEDY

A provider who is dissatisfied with the appeal decision may then use the judicial process to resolve the complaint. In compliance with section 14104.5 of the Welfare and Institutions Code, the provider must seek "judicial remedy" NO LATER THAN ONE YEAR after receiving notice of the decision.

First Level Appeals



1. Submit within 90 days
2. Use letterhead *not* a CIF
3. Letter must specifically request a 1st Level Appeal
4. Send all information/copies to uphold the request
5. Send Appeals directly to the Appeals address
6. Office will receive written notification from Denti-Cal within 21 days
7. Last recourse with Denti-Cal

EXPLANATION OF BENEFITS

DENTI-CAL

CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609



LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **1234567899**

CHECK
No **00596352**

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 08/15/12 PAGE NO. 1
of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

BENEFICIARY NAME				MEDI-CAL I.D. NO.	BENE ID	SEX	BIRTH DATE			
DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID

ADJUSTMENT CLAIMS



B	LAST	FIRST		99999999D	99999999D	F	mm/dd/yy
C #30:	NEW OR ADDITIONAL DOCUMENTATION SUBMITTED						
C	12168101357	15	D7210	06/10/12	A	266B	- 95.00 - .00 - .00
C		14	D2140	06/10/12	A		- 50.00 - 39.00 - 39.00
C		13	D2140	06/10/12	A		- 50.00 - 39.00 - 39.00
CLAIM TOTAL							-195.00 - 78.00 - 78.00



B	LAST	FIRST		99999999D	99999999D	F	mm/dd/yy
C #30:	NEW OR ADDITIONAL DOCUMENTATION SUBMITTED						
C	12168101357	15	D7210	06/10/12	P		95.00 85.00 85.00
C		14	D2140	06/10/12	P		50.00 39.00 39.00
C		13	D2140	06/10/12	P		50.00 39.00 39.00
CLAIM TOTAL							195.00 163.00 163.00
*TOTAL ADJUSTED CLAIMS							.00 85.00 85.00
**PROVIDER CLAIMS TOTAL							132.00 186.00 186.00

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00				186.00

Additional Services

Offered By
Denti-Cal



TELEPHONE INQUIRIES



Provider

For inquiries or general information, call the Denti-Cal Customer Service Telephone Center toll-free at (800) 423-0507. When calling, please be prepared with the following information where applicable:

1. Billing provider name and provider number
2. Patient's name and ID number
3. Type of treatment
4. Document Control Number of claim or TAR
6. Date of service & billed amount
7. Check voucher number

The TSC representatives are available to answer questions from 8:00 a.m. to 5:00 p.m. Monday through Friday (excluding holidays). Denti-Cal encourages the use of the toll-free line for inquiries whenever possible. Most inquiries can be answered immediately by our telephone representatives. However, if the inquiry cannot be answered immediately, it will be routed to the telephone inquiry specialist and will be answered by mail within 10 days of the receipt of the original telephone call.

Denti-Cal would like to give the best possible service and asks that the toll-free number be for provider assistance only. Please do not give the provider toll-free number to the beneficiaries.

Beneficiaries

The Beneficiary TSC toll-free line is available from 8:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays). The toll-free number is (800) 322-6384.

Beneficiaries or their authorized representatives may use this toll-free number. Representatives must have the beneficiary's name and ID number in order to receive information from the California Medi-Cal Dental Program.

Information about the program is available from the Beneficiary toll-free telephone operators. A few of the services are listed below:

1. Referrals to Denti-Cal dentists
2. Complaints and grievances
3. Assistance with scheduling . rescheduling Clinical screenings

4. Information about Share of Cost and copayments
5. Information about denied, modified or deferred TARs

INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

The Denti-Cal IVR is an automated inquiry system for use by providers. Using a touch-tone telephone, providers are able to communicate directly with an automated voice response system. Providers can access the IVR System by dialing the toll-free information line (800) 423-0507 from a touch tone telephone. The IVR is available 24 hours a day, 7 days a week for information that can be accessed without a provider number. The menu options that do not require entering a provider number include:

- Billing criteria for procedures most frequently inquired about by providers
- Upcoming schedule of provider seminars for the caller's area
- A monthly news flash consisting of items of interest to providers
- Information about ordering Medi-Cal dental forms
- Information about enrollment in the Medi-Cal Dental Program
- Transfer to a telephone representative for further inquiry

The hours for accessing information requiring a provider number are Monday through Sunday from 2:00 a.m. to 12:00 p.m. The optimum time to call is between 6:00 a.m. and 9:00 a.m. or between 12:00 p.m. and 1:30 p.m. when calls are at their lowest level. The menu options that do require entering a provider number include:

- Patient history relative to specific service limited procedures
- Status of outstanding claims and/or TARs that the caller has submitted
- Provider financial information (next check amount and net earnings for the current or previous year)



WRITTEN INQUIRIES

Written correspondence regarding billing procedures and general questions about dental policy and regulations will be acknowledged within five work days by a computer-generated postcard. A final written response to written correspondence will be made within 20 State work days.

ON-SITE VISITS

A Provider Representative is available for on-site visits to assist providers with any inquiries that cannot be resolved by telephone or written correspondence. Denti-Cal will determine the necessity of an on-site visit.

OTHER COVERAGE

In cases where the patient has other dental coverage, Denti-Cal is always considered the secondary carrier. As the secondary carrier, Denti-Cal is required to pay only up to the maximum allowed amount for the covered benefits and only if the primary carrier pays less than the maximum Denti-Cal allowance.

When billing Denti-Cal, attach the Explanation of Benefits (EOB), Remittance Advice (RA) or fee schedule from the primary carrier to the claim form. Insurance information must be submitted with a claim for payment but is not required for a TAR. The time limitation for billing Denti-Cal in cases where there is other coverage is one year.

Follow the prior authorization guidelines for each insurance carrier. Prior authorization must still be obtained from the Denti-Cal program.

MEDICARE/MEDI-CAL CROSSOVER CLAIMS

Medicare will pay for certain dental services. See the *Medicare/Medi-Cal Crossover Procedure Codes and Descriptions* list in the Denti-Cal Provider Handbook for procedures that qualify. Denti-Cal processes claims and TARs for Medicare covered dental services in accordance with the following Medicare/Medi-Cal crossover policies and procedures:

1. If a provider is not a Medicare provider, indicate this in the comments section, Box 34 on the claim form. Submit the claim directly to Denti-Cal for reimbursement.
2. A provider must be enrolled with the Medicare program to be reimbursed by Medicare.
3. An enrolled Medicare provider may submit claims to Denti-Cal for crossover procedures upon completion and approval of the MC 0804 Form. The provider must currently be enrolled in Medicare, must not be enrolled in Denti-Cal, and must be providing services to dual eligible beneficiaries. ***Existing Denti-Cal providers do not need to complete this form.*** The MC 0804 Form may be obtained from the Denti-Cal website or by calling the Toll Free Provider line.
4. Approved and paid Medicare dental services do not require prior authorization from Denti-Cal.
5. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a patient and has no direct bearing on the coverage or exclusion of any given procedure.

HOSPITAL CASES

When dental services are provided in an acute care general hospital or a surgicenter, document the need for hospitalization (e.g., retardation, physical limitations, age, etc.).

To request authorization to perform dental-related hospital services, providers need to submit a TAR with radiographs/photos and supporting documentation to Denti-Cal. Prior authorization is required only for the following services in a hospital setting: laboratory processed crowns/bridges, prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from the Denti-Cal program, even if they are provided in an outpatient hospital setting. In all cases, an operating room report or hospital discharge summary must be submitted with your claim for payment.

Services that require prior authorization may be performed on an emergency basis; however, the reason for the emergency services must be documented. Enclose a copy of the operating room report and indicate the amount of time spent in the operating room.

Hospital Inpatient Dental Services (*Overnight or Longer*)

If a provider is required to perform services within a hospital setting, the provision of the medical support services will depend on how the Medi-Cal beneficiary receives their medical benefits. Beneficiaries may receive medical benefits through a number of different entities:

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

Refer to your Denti-Cal Provider Handbook under Beneficiary Eligibility to determine the entity providing a beneficiaries medical services.

Requesting Hospital Dental Services for Medi-Cal Beneficiaries Enrolled in the Medi-Cal (FFS) Program

Authorization is required from Medi-Cal to admit the patient into the hospital. This

California Medi-Cal Dental Program
BASIC TRAINING SEMINAR

authorization must be submitted on the *Medi-Cal Form 50-1*, which should be sent directly to:

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

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

If your patient requires emergency hospitalization, a ‘verbal’ authorization is not available through the Medi-Cal field office. If the patient is admitted as an emergency case, the provider may indicate in the Verbal Authorization Box on the Medi-Cal Form 50-1, “Consultant Not Available” (CNA). An alternative is to admit the patient as an emergency case and submit the 50-1 retroactively within ten working days to the Medi-Cal field office.

Your claim for payment of dental services is submitted to Denti-Cal and must be accompanied by a statement documenting the need and reason the emergency service was performed. Include a copy of the operating room report.

Requesting Hospital Dental Services for Medi-Cal Beneficiaries Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans

The dentist must contact the patient’s medical plan to arrange for hospital or surgicenter admission and medical support services. All medical plans that provide services to Medi-Cal managed care beneficiaries are contractually obligated to provide medical support services for dental treatment. If the Medi-Cal Field Office receives a Form 50-1 for a Medi-Cal patient who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

MAXILLOFACIAL-ORTHODONTIC SERVICES (MF-O)

All MF-O surgical and prosthetic services, TMJ dysfunction services, and services involving cleft palate/cleft lip require prior authorization. The exceptions to this are diagnostic services and those services performed on an emergency basis. Providers and their staff should be aware of the procedure codes specific to the MF-O program. These codes are listed in your *Denti-Cal Provider Handbook*.

ORTHODONTIC SERVICES

Orthodontic benefits for eligible individuals under the age of 21 are available under the California Medi-Cal Dental Program **when medically necessary**. Services must be performed by a qualified orthodontist who is enrolled as a Denti-Cal provider. This program covers handicapping malocclusion, cleft palate/lip, and cranio-facial anomalies cases. A Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet must be submitted to document the medical necessity. To document a handicapping malocclusion, it is necessary to have a minimum score of 26 on the HLD score sheet. There are also six automatic qualifying conditions: cleft palate deformity, cranio-facial anomaly, a deep impinging overbite causing destruction of the palatal soft tissue, an anterior cross-bite causing clinical attachment loss and recession of the gingival margin, severe traumatic deviation, or an overjet greater than 9mm or a mandibular protrusion greater than 3.5mm. See Provider Handbook, page 9-11 for more information.

CALIFORNIA CHILDREN'S SERVICES (CCS)

The CCS program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition. Patients must apply to CCS to be eligible for services provided under this program. The patient's caseworker can refer the patient to his or her local CCS county or regional office.

All CCS dental/orthodontic providers must be enrolled and active in the Denti-Cal program prior to receiving payment. If a provider has a valid authorization issued by the CCS program, the authorization will be honored through the expiration date. Continue using the same processing guidelines that were in place when the services were authorized.

Program Guidelines:

All CCS beneficiaries are subject to the scope of benefits, prior authorization and processing guidelines as defined in the Denti-Cal Provider Handbook. The CCS Program only authorizes dental services if such oral conditions affect the beneficiary's /CCS-eligible condition. See Provider Handbook, page 9-1 for more information.

CCS/Medi-Cal: The CCS program will no longer issue authorizations for CCS/Medi-Cal beneficiaries. Providers are to submit all claims and TARs directly to Denti-Cal. If a beneficiary requires services beyond the scope of the Denti-Cal program, they may qualify for the Early and Periodic Screening, Diagnosis and Treatment – Supplemental Services (EPSDT-SS) program.

CCS-only & CCS/Healthy Families (CCS/HF): CCS-only and CCS/HF eligible beneficiaries will continue to require service authorization requests (SARs) from CCS. Providers must request a SAR from the CCS county or regional office prior to submitting claims and TARs to Denti-Cal.

THE PROFESSIONAL COMPONENT

Denti-Cal has a professional unit consisting of dental consultants who are licensed dentists. The consultants review all claims and TARs which require professional judgment. These dental consultants assist Denti-Cal Provider/Beneficiary Services and Clinical Screening departments with reevaluations and special cases.

In addition, there are clinical screening dentists located throughout the state. They are responsible for pre-screening cases that may require clinical evaluation under the guidelines of the Denti-Cal program.

After the clinical screening dentist has examined the patient, the screening report is reviewed by a Denti-Cal dental consultant. The claim or TAR is subsequently approved, modified, or denied. The Denti-Cal clinical screening dentists also do post-operative screenings.

Important Phone Numbers & Websites for Denti-Cal Providers



PROVIDER TOLL-FREE LINE	800-423-0507
BENEFICIARY TOLL-FREE LINE	800-322-6384
A.E.V.S. (to verify beneficiary eligibility)	800-456-2387
A.E.V.S. HELP DESK (Medi-Cal)	800-541-5555
P.O.S. / INTERNET HELP DESK	800-541-5555
MEDI-CAL WEBSITE (to verify beneficiary eligibility)	www.medi-cal.ca.gov
DENTI-CAL WEBSITE	www.denti-cal.ca.gov
EDI TECHNICAL SUPPORT	916-853-7373
DENTI-CAL FORMS (FAX #)	877-401-7534
CA DEPT OF PUBLIC HEALTH http://hfcis.cdph.ca.gov/servicesandfacilities.aspx	

Denti-Cal's Electronic Data Interchange (EDI)





Did You Know?

- **Denti-Cal has been accepting EDI documents since 1994**
- **EDI claims are processed an average of five days faster than paper claims**
- **Approximately 47% of Denti-Cal's incoming documents are received electronically**



Why EDI?

- **To maximize computer capabilities**
- **To make billing simpler**
- **To have fewer rejections**
- **To have tracking capabilities**
- **To receive payment faster**
- ***Saves Money - Estimate your savings on the NDEIEC website***

- **From the website:**
www.ndedic.org
- **Click on the 'Publications' Tab & select the 'ROI Calculator'**
- **Enter your statistics**
- **Click 'Calculate' to see your savings**

See What EDI Can Do For You!

Providers can determine their own potential savings in submitting claims electronically by using the ROI (Return on Investment) Calculator available on the National Dental EDI Council (NDEDIC)* web site (www.ndedic.org).

Follow these easy steps:

The screenshots illustrate the process of using the ROI Calculator. Step 1 shows the NDEDIC homepage. Step 2 shows the 'Publications' menu with 'ROI Calculator' selected. Step 3 shows the 'ROI Calculator' form with various input fields for practice statistics. Step 4 shows the 'Calculate' button and the resulting 'ROI STATISTICS' table.

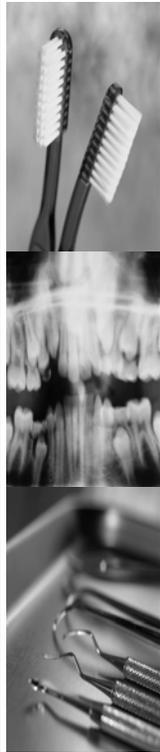
For more information about submitting electronically to Denti-Cal, call Provider Services toll-free at (800) 423-0507 or call EDI Support at (916) 853-7373. Requests may also be sent by email to denti-caled@delta.org.

*The National Dental EDI Council (NDEDIC) is a nationally recognized organization whose purpose is to unite dentists, clearinghouses, practice management system vendors and dental payers in promoting the value and increasing the utilization of electronic commerce within the dental industry and to offer educational opportunities in dental EDI.



Getting Started With EDI

- **Must have practice management software or access to the Internet**
- **If necessary enroll with the clearinghouse that works with the office's practice management software**
- **Must enroll with Denti-Cal's EDI Department**
- **Do not send electronically until the office has been notified of activation by Denti-Cal**
- **Take a few minutes to read the *EDI How-to Guide***



When Preparing An EDI Document...

- Complete required fields
- Check for accurate information
- Use the comment or note section of the software to provide additional written information
- Use only the CDT 11-12 procedure code format



Clearinghouse Daily Reports

- **Submitter Report** -

This report is generated prior to the transmission of the claims to the clearinghouse

- **Transmission Summary Report** -

This is verification that the claims have been received by the clearinghouse and have been submitted to the appropriate payers



Denti-Cal's

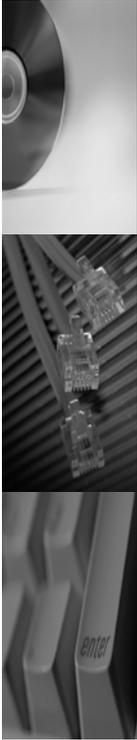
EDI

Reports

CP-O-973-P Daily EDI Documents Received Today



PROV/SVC OR NPI	PROVIDER DCN	BASE DCN	RECIPIENT LAST	NAME FIRST	SSN/CIN/ OR MEDS
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	30.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	200.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	55.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	77.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: T	SUBMITTED FEE:	331.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	1430.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	30.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: T	SUBMITTED FEE:	100.00	
0000000000	0000000000	12000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: T	SUBMITTED FEE:	50.00	
TOTAL PROV/SVC OFC DOCUMENTS :					9



The Binder System

- One way to manage the EDI reports is “The Binder System”



- In a standard three ring binder:
 - Place index tabs numbered 1-31 (for the days of the month)
 - File the *Transmission or CP-O-973-P report* under the date billed from the office
- *This gives a starting point to track the EDI claims*

The Binder System



PROV/SVC OR NPI	PROVIDER DCN	BASE DCN	RECIPIENT LAST	NAME FIRST	SSN/CIN/ OR MEDS	
REPORT ID: CP-O-973-P DENTI-CAL RUN ON: 07/29/12 PERIOD ENDING: 07/28/12 PROVIDER/SVC OFC PAGE: 1 PROGRAM ID: DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY						
• 0000000000	MCD141	12XXXXXXXXX	FIRST	NAME	0000000000	
• MEDI CAL NBR:	000000000000000000	DOC TYPE: C	SUBMITTED FEE:	117.00		
• 0000000000	Y000000000000000000	12XXXXXXXXX	FIRST	NAME	0000000000	07/31/12
• MEDI CAL NBR:	000000000000000000	DOC TYPE: C	SUBMITTED FEE:	90.00		
• 0000000000	Y000000000000000000	12XXXXXXXXX	FIRST	NAME	0000000000	07/31/12
• MEDI CAL NBR:	000000000000000000	DOC TYPE: C	SUBMITTED FEE:	219.00		
• 0000000000	Y000000000000000000	12XXXXXXXXX	FIRST	NAME	0000000000	
• MEDI CAL NBR:	000000000000000000	DOC TYPE: T	SUBMITTED FEE:	17.00		
• TOTAL PROV/SVC OFC DOCUMENTS :						4

- Indicate the date each claim is processed on the *CP-O-973-P report*
- Remove page once all claims are processed
- *This quickly identifies the claims that have not been processed at the end of each month*



EDI Documents Waiting Return (CP-O-978-P)

REPORT ID: CP-O-978-P DENTI-CAL RUN ON: 06/12/12
 PERIOD ENDING: 06/17/12 PROVIDER/SVC OFC PAGE: 1
 PROGRAM ID: DCB978BS DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > **7 DAYS**

PROV/SVC OR NPI	ISSUE DATE	DAYS SNCE	SSN/CIN/ OR MEDS	MEDI-CAL NUMBER	RECIPIENT LAST	NAME FIRST	TYPE OF REQUEST
0000000000	05/04/12	40	000000000		LAST	FIRST	XRAY/ATTCH
PROV DCN: 0000000000			BASE DCN: 12000000000		DOC TYPE: C	SUB AMT: 30.00	
0000000000	05/20/12	24	000000000	00000000000000	LAST	FIRST	ADDIT DOC
PROV DCN: 0000000000			BASE DCN: 12000000000		DOC TYPE: T	SUB AMT: 1133.00	
0000000000	05/24/12	20	000000000	00000000000000	LAST	FIRST	ADDIT DOC
PROV DCN: 0000000000			BASE DCN: 12000000000		DOC TYPE: T	SUB AMT: 1486.00	
0000000000	05/27/12	17	000000000	00000000000000	LAST	FIRST	XRAY/ATTCH
PROV DCN: 0000000000			BASE DCN: 12000000000		DOC TYPE: C	SUB AMT: 100.00	

TOTAL PROV/SVC OFC DOCUMENTS : 4

Example #1

DENTI-CAL PROVIDER ID: XXXXXXXX
 PATIENT MEDS ID: _____
 PROV. DCN: _____
 DENTI-CAL DCN: 12000000000
 DCN: _____
 PREVIOUS X-RAYS _____
 AND/OR _____
 ATTACHMENTS: _____
 PROVIDER NAME _____
 ADDRESS _____
 CITY, CA 90000

Example #2

(CP-O-RTD-P) NOTICE OF RESUBMISSION 11/19/12 20:43:19 PAGE 1 OF 1 BUSINESS NAME AND ADDRESS RTD ISSUE DATE: 11-19-12
 SERVICE OFFICE/ PICTITIOUS NAME 1234567891 RTD DUE DATE: 01-03-13
 ADAM, JAMES, DMD INC
 30 CENTER STREET DOCUMENT TYPE: TAR
 ANYTOWN, CA 90250-3807 BEGINNING DOS: 000000000000000
 PROVIDER DCN: 000000000000000
 PATIENT INFORMATION AMOUNT
 LAST NAME FIRST NAME MEDICAL ID NBR DENTAL REC BILLED DCN
 LAST FIRST 000000000000000 900.00 12000000000 7
 CLAIM INFORMATION FIELD CLAIM SUBMITTED PROCEDURE
 BLOCK NO. LINE INFORMATION CODE
 TOOTH-CODE 26 01 10 D2791
 ERROR CD: 32 DESC: SUBMIT CURRENT X-RAY(S) SHOWING APICES OF TOOTH
 CORRECT INFORMATION:
 TOOTH-CODE 26 01 10 D2791
 ERROR CD: 31 DESC: SUBMIT CURRENT X-RAYS/PHOTOGRAPHS
 CORRECT INFORMATION:
 X _____ DATE _____
 SIGNATURE DATE

NOTE: PLEASE CORRECT THE CLAIM/TAR/NOA. RESUBMIT A COPY OF THIS FORM THRU THE MAIL. MAIL ANY REQUIRED X-RAYS/ATTACHMENTS IN THE APPROPRIATELY COLORED ENVELOPE, WRITING IN THE DOCUMENT CONTROL NUMBER (DCN). PLEASE INCLUDE THE DENTI-CAL ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH DENTI-CAL.



NOTICE OF RESUBMISSION (RTD)

(CP-O-RTD-P) NOTICE OF RESUBMISSION 11/19/12 20:43:19 PAGE 01 OF 01
 BUSINESS NAME AND ADDRESS RTD ISSUE DATE: 11-19-12
 SERVICE OFFICE/ PICTITIOUS NAME 1234567891 RTD DUE DATE: 01-03-13
 ADAM, JAMES, DMD INC
 30 CENTER STREET DOCUMENT TYPE: TAR
 ANYTOWN, CA 90250-3807 BEGINNING DOS: 000000000000000
 PROVIDER DCN: 000000000000000
 PATIENT INFORMATION AMOUNT
 LAST NAME FIRST NAME MEDICAL ID NBR DENTAL REC BILLED DCN
 LAST FIRST 000000000000000 900.00 12000000000 7
 CLAIM INFORMATION FIELD CLAIM SUBMITTED PROCEDURE
 BLOCK NO. LINE INFORMATION CODE
 TOOTH-CODE 26 01 10 D2791
 ERROR CD: 32 DESC: SUBMIT CURRENT X-RAY(S) SHOWING APICES OF TOOTH
 CORRECT INFORMATION:
 TOOTH-CODE 26 01 10 D2791
 ERROR CD: 31 DESC: SUBMIT CURRENT X-RAYS/PHOTOGRAPHS
 CORRECT INFORMATION:
 X _____ DATE _____
 SIGNATURE DATE

NOTE: PLEASE CORRECT THE CLAIM/TAR/NOA. RESUBMIT A COPY OF THIS FORM THRU THE MAIL. MAIL ANY REQUIRED X-RAYS/ATTACHMENTS IN THE APPROPRIATELY COLORED ENVELOPE, WRITING IN THE DOCUMENT CONTROL NUMBER (DCN). PLEASE INCLUDE THE DENTI-CAL ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH DENTI-CAL.



NOTICE OF AUTHORIZATION (NOA)

(CP-O-NOA-P) NOTICE OF AUTHORIZATION 08/17/12 01:43:53 PAGE 01 OF 01
 DCN: 10000000000 7 AUTHORIZATION PERIOD FROM 08/17/12 TO 02/13/13

RE-EVALUATION IS REQUESTED (X FOR YES)

PATIENT NAME(LAST, FIRST, MI) SEX BIRTHDATE MEDI-CAL-ID NO
 LAST FIRST M XX/XX/XX 0000000000000

PATIENT DENTAL RECORD NO. :
 PROVIDER DOC CONTROL NUMBER: Y0ABZV01CROM100-0

X-RAYS ATTACHED (X FOR YES) HOW MANY? ACCIDENT / INJURY (X FOR YES)
 OTHER ATTACHMENTS (X FOR YES) EMPLOYMENT RELATED (X FOR YES)
 OTHER DENTAL COVERAGE (X FOR YES) CHDP (X FOR YES)

BUSINESS NAME AND ADDRESS 1234567891 BIC ISSUE DATE: _____
 ADAM, JAMES, DDS APC

30 CENTER STREET EVC #: _____
 ANYTOWN CA 90250-3807

TO SURF	LN	DESCRIPTION-OF-SVC	DATE-PER	QTY	PROC	FEE	ALLOW	ADJ-C	PROVID
18	01	PREFABRICATED POST	01	D2954	100.00	74.25			
18	02	FULL CAST METAL CROW	01	D2791	800.00	336.60			

DATE PROSTHESIS ORDERED : _____ TOTAL FEE CHARGED 900.00
 PROSTHESIS LINE ITEM : - - - - - TOTAL ALLOWANCE 410.85
 PATIENT SHARE-OF-COST AMT. _____
 OTHER COVERAGE AMT. _____
 DATE BILLED _____

COMMENTS:
 PAYMENT REQUEST MUST HAVE RENDERING PROV ID
 ** PLEASE NOTE: THIS BENEFICIARY MAY ONLY BE ELIGIBLE
 UNDER A PHP, MCP, GMC, HMO OR DMC WHICH INCLUDES DENTAL.
 PLEASE VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICES.

X _____ SIGNATURE DATE

NOTE: PLEASE REFER TO THIS NBR (10000000000) ON ALL YOUR COMMUNICATIONS, WITH
 DENTI-CAL, INCLUDING ELECTRONIC TRANSACTIONS CONCERNING THIS DOCUMENT.



Denti-Cal EDI Support

**Please contact Denti-Cal's EDI department
 for additional information:**

***EDI Support may be reached by phone or
 email at:***

(916) 853-7373

denti-caledi@delta.org

GLOSSARY

BILLING PROVIDER: The dentist who bills or requests authorization for services on the treatment form.

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM: The State approved universal form used by the provider to request prior authorization of services, and/or the form submitted by the provider to request payment for services performed.

CLAIM INQUIRY FORM (CIF): The form used by the provider for tracing a claim or TAR, or for requesting a reevaluation or adjustment to a previously submitted claim.

CORRESPONDENCE REFERENCE NUMBER (CRN): An identifying number assigned to all telephone correspondence, written correspondence and CIF's received by Denti-Cal.

DENTI-CAL: The Fee-for-Service portion of the California Medi-Cal Dental Program.

DENTI-CAL BULLETIN: A publication with information regarding program updates, pertinent legislative action, procedure clarifications, and other important items which affect the California Medi-Cal Dental Program. The bulletins may be accessed from the Denti-Cal website.

DENTI-CAL PROVIDER HANDBOOK: A reference guide prepared by Denti-Cal for all providers enrolled in the California Medi-Cal Dental Program. It contains the criteria for dental services, program benefits, exclusions, limitations, and instructions for completing forms used in the Denti-Cal program. The Handbook may be accessed from the Denti-Cal website.

DOCUMENT CONTROL NUMBER (DCN): An identifying number assigned to all billing documents received by Denti-Cal. The DCN enables Denti-Cal to track the document throughout the automated processing system.

NOTICE OF AUTHORIZATION (NOA): A computer-generated form sent to the provider following final processing of a TAR by Denti-Cal. When the NOA is returned to Denti-Cal by the provider, it becomes a claim submitted for payment of services rendered.

PROVIDER: Individual dentists, dental group, dental school, or dental clinic.

RESUBMISSION TURNAROUND DOCUMENT (RTD): A computer-generated form which Denti-Cal sends to the provider to request missing or additional information needed to complete processing of a claim, TAR or NOA.

RENDERING PROVIDER: The dentist who provides services that are billed under the billing provider's name and billing provider number. The rendering provider may be the same as, or different from the billing provider.



Denti-Cal

California Medi-Cal Dental Program

CONTINUING EDUCATION CERTIFICATE OF COMPLETION

Provider Name: Delta Dental of California Date: _____

Course Title: Clarification of Denti-Cal Concepts -
A Utilization Primer - Basic Seminar

Registration #: 03-2210- Units Earned: 3

Licentiate's Name: _____ License #: _____

Provider Signature: [Handwritten Signature]

Licentiate's Signature: _____

Excerpts from State Board Regulations Pertaining to Continuing Education Courses:

Section 1017, para E - to wit:

A licentiate who applies for license renewal, shall, on a form provided by the board, provide a summary of continuing education units earned during the license renewal period. The licentiate shall retain for a period of four years the certifications issued to him/her at the time he/she attended the course and shall forward such certifications to the board only upon written request by the board.

Section 1016, para G - to wit:

“It shall be the responsibility of the provider to furnish a written certification to the licentiate certifying that the licentiate has met the attendance requirements of the course. Such certification shall not be issued until completion of the course and shall contain the provider's name, course registration number, dates attended and units earned filled in by the provider. Additionally, space shall be provided for the licentiate's printed name, signature and license number.”

P.O. Box 15609 * Sacramento, CA 95852-0609 * (800) 423-0507 * (916) 853-7373

BASIC & EDI SEMINAR

Evaluation Form

We value your opinion regarding the content and presentation of this training seminar. Please take a moment to answer the questions below and make suggestions on subjects for future seminars.

1. Do you have Internet access to utilize the Denti-Cal website? Yes No

2. How valuable was the information on the location and content of the Denti-Cal website?
 Very Valuable Above Average Average Below Average

3. How valuable was the overview of the Enrollment process?
 Very Valuable Above Average Average Below Average

4. How valuable was the overview of the Eligibility process?
 Very Valuable Above Average Average Below Average

5. How valuable was the information presented on the Forms process?
 Very Valuable Above Average Average Below Average

6. How valuable was the information presented on the Appeals process?
 Very Valuable Above Average Average Below Average

7. How effective was the trainer in presenting this seminar?
 Very Effective Above Average Average Below Average

8. What was your overall evaluation of the seminar in acquainting you with the Denti-Cal program?
 Very Valuable Above Average Average Below Average

Please provide your contact information:	
Practice Name:	NPI #:
Phone #:	Email Address:

<input type="checkbox"/> Yes, I would like a representative to contact me for assistance with questions I still have.	
Best time to call:	Contact Person:

What helpful information will you take back to your office? _____

General comments or suggestions: _____