

***THE  
DENTI-CAL  
ORTHODONTIC  
PROGRAM***



***Seminar Packet***

**Revised 5/9/12**





# Denti-Cal

California Medi-Cal Dental Program

Dear Denti-Cal Provider and Staff:

Welcome! We have prepared this packet especially for orthodontists and their staff who attend our provider training seminar for the Orthodontic Services Program under the California Medi-Cal Dental Program known as Denti-Cal.

The material contained in this packet is designed to familiarize you with the Denti-Cal orthodontic program utilizing the CDT 11-12 procedure codes, policies, procedures and billing requirements. For further information, please refer to the Provider Handbook located on the Denti-Cal website at [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov).

We appreciate your interest in the California Medi-Cal Dental Program and hope you will benefit from the information presented at today's seminar. If you have any questions, please call our toll-free number, (800) 423-0507.

Sincerely,

Arbie Melvin  
Director, Customer Service  
Medi-Cal Dental Program

# The Denti-Cal Website

www.denti-cal.ca.gov

The screenshot shows the Denti-Cal website interface. Callouts point to various sections: 'Providers' points to the top navigation bar; 'Beneficiaries' points to the 'Beneficiaries' link in the top navigation bar; 'Most Popular Links' points to the 'MOST POPULAR LINKS' section on the left; 'What's New' points to the 'WHAT'S NEW' section on the right; and 'Important Reminders' points to the 'IMPORTANT REMINDERS' section at the bottom of the page.

# 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 may need both a 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 billing *and* rendering provider numbers

- Through the Denti-Cal website: <http://www.denti-cal.ca.gov>:

- NPI Collection system or;
- Hard copy Registration Form

# Orthodontic Program Benefits

- In Feb. 1991 the Denti-Cal program expanded its benefits to include orthodontic care
- Orthodontic benefits are to age 21, *with no extended benefits*
- Are only provided for the following medically necessary conditions:
  - Handicapping Malocclusion
  - Cleft Palate/Lip
  - Craniofacial Anomalies



# Enrollment & Certification

## To Participate in the Orthodontic program:

- ❖ **Providers must enroll as a Qualified Orthodontist, and**
- ❖ **Be in an 'active' Denti-Cal enrollment status**



# Certification for Denti-Cal Orthodontists

Section 51223, Title 22, the California Code of Regulations defines a qualified orthodontist as meeting the following requirements:

1. The Orthodontist must confine his/her practice to the specialty of orthodontics, and
2. Has successfully completed a course of advanced study in orthodontics for 2 years or more in programs recognized by the Council on Dental Education of the American Dental Association, or
3. Has had advanced training in orthodontics prior to July 1, 1969 & is a member of, or eligible for membership in the American Association of Orthodontics.

# The New Orthodontic Provider



- Will request an *Enrollment & Certification* packet from Denti-Cal
- Will be notified in writing upon completion of the enrollment process
- New Billing Providers will receive:
  - Billing Provider Number  
*(NPI for the type of business)*
  - Personal Identification Number (PIN)
- Rendering Provider Number(s)  
*(NPI for the individual)*

# Additional Information...

- Billing Intermediaries
- Changes to your Practice
- Denti-Cal Provider Handbook
- Bulletins



# Eligibility

- County Dept. of Social Services establishes eligibility
- Eligibility information is transferred to the State
- Verify eligibility monthly
- Eligibility Verification Confirmation Number (EVC)



# The Medi-Cal Benefits Identification Card (BIC)

	<b>State of California</b>
<b>Benefits Identification Card</b>	
ID No. 9999999999999999	
FIRST M. LAST	
M mm dd yyyy	Issue Date 01 11 05
	
<i>First M. Last</i>	
SIGNATURE	
<small>This card is for identification ONLY. It does not guarantee eligibility. Carry this card with you to your medical provider. DO NOT THROW AWAY THIS CARD. Misuse of this card is unlawful.</small>	

## Elimination of Optional Adult Dental Services

- The elimination of optional adult dental benefits does not apply to children.
- The Orthodontic Services Program is to age 21



## Beneficiary Dental Cap

- \$1800.00 calendar year maximum is for adults only  
(21 years and older)
- Children are exempt from Cap
- Medi-Cal Orthodontic Program is exempt from Cap  
(Ortho program is to age 21)



# Eligibility

- The Medi-Cal program verifies eligibility
- 3 ways to verify eligibility:
  - Touch Tone Telephone
  - Internet
  - POS Device
- POS/Internet are free of charge
- Request the POS Network/Internet Agreement from the POS/Internet Help Desk or Medi-Cal website



# Web Eligibility

## Screen #1

# Web Eligibility

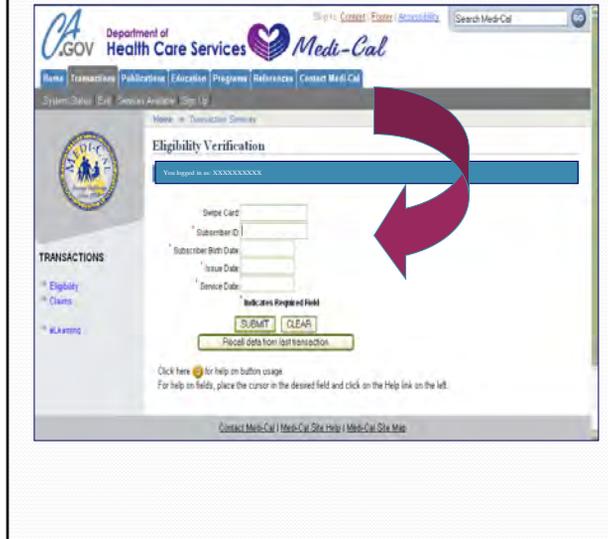
## Screen #2

# Web Eligibility

## Screen #3

# Web Eligibility

## Screen #4



# Web Eligibility

## Screen #5



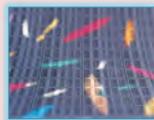
# Aid Codes

- Not everyone receiving Medi-Cal has full-scope benefits
- Limited / Restricted Services
- Call Medi-Cal if unsure about eligibility messages



# Other Insurance Coverage

- Managed Care Plans
- Other Coverage
  - ✓ Indemnity Plans
  - ✓ Denti-Cal is always secondary carrier / Bill Other Coverage first
  - ✓ Follow prior-authorization guidelines for ***each*** insurance



# Share of Cost (SOC)

- 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



## **ENROLLMENT AND CERTIFICATION**

To participate in the Denti-Cal Orthodontic Program, providers must be enrolled as a qualified orthodontist and be in an "active" Denti-Cal enrollment status. To check current status or enrollment, call the Denti-Cal provider toll-free line, (800) 423-0507, and a telephone representatives will be able to give current status information.

Orthodontists who wish to submit claims for services provided to eligible Medi-Cal and California Children's Services (CCS) dental beneficiaries must first complete the Orthodontia Provider Certification form. As defined in Title 22, the California Code of Regulations, a "qualified orthodontist" is a dentist who "confines his/her practice to the specialty of orthodontics" and who either "has successfully completed a course of advanced study in orthodontics of two years or more in a program recognized by the Council of Dental Education of the American Dental Association" or "has completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontics."

### **New Providers**

New orthodontic providers will need to request an enrollment and certification packet to participate in the Denti-Cal program. Notification will be made by a confirmation letter after enrollment and certification procedures have been completed. Do not provide services to Medi-Cal dental beneficiaries until the confirmation letter has been received. This letter includes the provider's billing number. The provider number will be the National Provider Identifier (NPI) Number that the enrollee obtained from NPPES for their type of business. A second letter will include a personal identification number (PIN.) The PIN is a six-digit number which will enable access to financial information and/or confirm beneficiary eligibility through the automated eligibility verification system (AEVS).

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; change of 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 Dept.  
P. O. Box 15609  
Sacramento, CA 95852-0609**

Enrollment forms are also available online at the Denti-Cal website, [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov). For more in depth information on enrolling as a Certified Orthodontist, refer to the Denti-Cal Provider Handbook, Section 3: Enrollment, and Section 9: Special Programs.

## **Rendering Providers**

Rendering providers must be enrolled in the Denti-Cal program prior to rendering services to Denti-Cal beneficiaries, and only a Certified Orthodontist may render services to a Denti-Cal Orthodontic beneficiary. The rendering provider number will be the NPI number that the doctor obtained from NPES based on their personal information.

## **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](http://www.denti-cal.ca.gov).

The *Provider Handbook* has been developed to assist the provider and office staff with participation in the Denti-Cal Orthodontic Services 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. For specific information on the Orthodontic Services Program, refer to Section 9: Special Programs.

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 usually published on a monthly basis to keep providers informed of the latest developments in the program. The "Provider Bulletins" section of the website should be checked frequently for current and up-to-date information regarding the Denti-Cal program.

## **ELIGIBILITY**

Eligibility of a beneficiary is determined by the local social services department in the county where the beneficiary resides. Eligibility is not determined by Denti-Cal. Once eligibility has been determined, the information is forwarded to the State of California. This information then becomes available to Denti-Cal for processing claims according to the eligibility established.

Beneficiaries are issued a plastic Benefits Identification Card (BIC) when eligibility is established. The identification card is not a verification of eligibility, but rather a means by which the provider may obtain eligibility and share-of-cost information. The initial card given to the beneficiary may be replaced in case of loss or theft. Should this occur, the beneficiary should report it to his or her social worker, and a new card will be issued within 2 – 10 working days. Please note, the new card will be given a new issue date.

## **Verifying Beneficiary Eligibility**

There are several ways eligibility may be established:

1. Automated Eligibility Verification System (AEVS) through a touch-tone telephone
2. Point-of-service (POS) network device
3. Internet access ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov))
4. Custom applications (technical specifications for offices with large volume and extensive computer systems)

This is where providers will utilize their PIN to access eligibility information. The beneficiary's ID card provides all the information necessary to access eligibility. The automated eligibility system will instruct which information needs to be entered. When the information is entered, a response verifying beneficiary information and eligibility status will be given. Information received will be:

1. Beneficiary's last name
2. First name, or first initial
3. County code
4. Primary aid code
5. Secondary aid code (if applicable)
6. Other information: Medi-Cal eligible, other coverage information, Pre-paid Health Plan (PHP) information, Health Maintenance Organization (HMO) Plans, Managed Care, Share-of-Cost, etc.
7. Eligibility Verification Confirmation (EVC) Number

## **AID CODES**

Know the aid code(s): Not everyone receiving Medi-Cal has full-scope benefits. A beneficiary may be given aid codes that reflect limited or restricted coverage. Some beneficiaries are limited to medical benefits only, such as ambulatory pre-natal care services. An example of restricted benefits would be emergency or pregnancy-related services only. These beneficiaries would not be eligible for orthodontic care under the Denti-Cal program.

## **OTHER INSURANCE COVERAGE**

The eligibility message may also indicate other coverage information if it applies. A beneficiary may have orthodontic benefits through another dental plan. Remember that Medi-Cal will always be the secondary carrier to all other coverage.

Each request for payment must include a copy of the Explanation of Benefits (EOB), fee schedule, or letter of denial from the other carrier. *Even with other coverage, orthodontic treatment must still be prior authorized by the Denti-Cal program.*

If a beneficiary is enrolled in a Managed Care Plan (MCP), Prepaid Health Plan (PHP), or Health Maintenance Organization (HMO) that includes dental benefits, orthodontic treatment must be rendered by a provider enrolled in that plan. There is no coordination of benefits with the Denti-Cal Fee-For-Service (FFS) program.

## **SHARE OF COST**

Share-of-Cost (SOC) information will be given in the eligibility message if it applies to the beneficiary. A SOC message will specify how much the beneficiary must agree to pay before becoming eligible for Medi-Cal benefits for the month. SOC is a procedure the Department of Health Care Services developed to ensure that an individual or family meets a predetermined financial obligation before receiving Medi-Cal benefits. This procedure is used to compute the dollar amount to be applied to any health care costs. Health care costs could be dental, medical, hospital or pharmaceutical charges. Always use usual, customary and reasonable (UCR) fees. If the SOC has been met when an update has been entered in the eligibility system, it will reflect this information or show the amount remaining. When updating SOC, do so by procedure code, not by the total amount for the visit.

Refer to the Provider Handbook, Section 4: Treating Beneficiaries, for further information on Aid Codes, Other Insurance or Share-of-Cost.

# **INSTRUCTIONS FOR *SHARE OF COST (SOC) CLEARANCE* USING THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS)**

To perform a SOC clearance using the AEVS, follow these steps:

- Call AEVS at 800-456-AEVS (2387)
- Enter the 6 digit PIN number (not the same as the NPI)
- Press '2' for the *share of cost* menu
- Press '1' to perform an update (clearance)
- Enter the beneficiary ID number, then the pound sign ( # )
- Enter the 2 digit month and 4 digit year of the beneficiary's birth date
- Enter the date of service, using 2 digits for the month, 2 digits for the day, and 4 digits for the year. (For example: Enter March 5, 2012 as 03052012)
- Enter the appropriate procedure code using the CDT-4 code format, followed by the #)
- Enter the total amount billed in the format of dollars followed by the star sign, and cents followed by the pound sign. (For example: \$20.50 would be entered as 20\*50#)

Verify that the amount is entered correctly by pressing '1' for 'yes' or '2' for 'no'. If '2' is pressed, re-enter the amount. If '1' is pressed, enter the case number (*if applicable*) followed by the (#) sign.

If the SOC is not fully satisfied, the amount deducted and the amount remaining will be indicated.

If the SOC is satisfied, the following information will be received:

- The first 6 letters of the last name
- The first initial of the first name
- The Eligibility Verification Confirmation (EVC) number
- The county code
- The aid code
- The amount deducted
- A message indicating the SOC is certified (cleared)
- A message indicating what type of eligibility the beneficiary has and if there are any restrictions or limitations to benefits

Eligibility can be delayed when other health care providers do not report payments made by the beneficiary. Instruct the beneficiary to take their receipt of payment to their caseworker so an update may be done. An alternative is to contact the other health care provider and ask that the SOC be updated immediately on behalf of the beneficiary.

# **Orthodontic Billing Forms & Procedures**



## **ORTHODONTIC BILLING FORMS AND PROCEDURES**

Orthodontic services are limited to only those who meet the general policies and requirements for medically necessary handicapping malocclusion, cleft palate, or cranio-facial anomalies cases set forth in Title 22 of the California Code of Regulations. Eligibility for these services end when the beneficiary reaches the age of 21, with no extended services allowed.

In administering the California Medi-Cal Dental Program, Delta Dentals' 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 Delta Dental to process claims and TARs as quickly and efficiently as possible. The forms used for billing as well as other related documents have been developed to simplify billing procedures. The forms, in both manual and computer-compatible formats, are available from the Denti-Cal forms supplier at no charge to providers.

The Handbook contains detailed, step-by-step instructions for completing each of the Denti-Cal forms. Section 6: Forms, contains a handy checklist to help complete treatment forms accurately. Section 9: Special Programs, contains detailed information specific to the orthodontic program, including enrollment and certification procedures and orthodontic claims processing.

All incoming documents are received and sorted in the Denti-Cal mailroom. Claims and TARs are separated from other incoming documents and general correspondence. Orthodontic treatment forms are assigned a unique 11-digit Document Control Number or DCN. The DCN is important because it identifies specific treatment forms so Denti-Cal can tell exactly where it is in the processing system, what has been done to that point, and if appropriate, what needs to be done to reach the final point of authorization or payment. By knowing this information, Denti-Cal can answer inquiries concerning the status of any treatment form received.

The dental office must accurately complete treatment forms to ensure proper and expeditious handling by Denti-Cal. A form which is incomplete or inaccurate causes delays in processing and/or requests for additional information. Please insure the required information is typed or printed clearly on the form.

# 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 performed the treatment
3. Emergency services must have written documentation which includes, but not limited to, the tooth/area, condition and specific treatment performed. The statement, 'An emergency existed' is NOT sufficient.

## CDT 11-12 Procedure Codes

D0140 = Limited Oral Evaluation

D0470 = Diagnostic Casts

D8080 = Comprehensive Ortho TX of the Adolescent Dentition  
(for all case types – fees will vary)

D8660 = Pre-Orthodontic TX Visit  
(for craniofacial anomalies cases only)

D8670 = Periodic Ortho TX Visit  
(for all case types – fees will vary)

D8680 = Orthodontic Retention  
(for all case types)

## The 1st Step...

- *The 1<sup>st</sup> step for Orthodontic treatment is to provide the Ortho Exam:*

D0140 = Limited Oral Evaluation

- *The exam includes completion of the 'Handicapping Labio-Lingual Deviation (HLD) Index CA Modification Score Sheet'*



## **Orthodontic Examination and Completion of the Handicapping Labiolingual Deviation Index California Modification Score Sheet (HLD)**

The first step will be to conduct the initial orthodontic examination called the Limited Oral Evaluation (Procedure D0140). This examination includes completion of the HLD Index Score Sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the beneficiary qualifies for medically necessary orthodontic services. Follow the instructions on the back of the form to assess the medical necessity. The qualifying conditions for treatment under the Denti-Cal Orthodontic Program are:

1. Cleft palate deformities
2. Cranio-facial anomaly. (A description of the condition from a credentialed specialist must be attached).
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite under the Orthodontic Services Program).
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present. (e.g., stripping of the labial gingival tissue on the lower incisors). Bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.
- 6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Submit photographs for this exception.
- 6B. Individual score of at least 26 points.

If one of the above conditions is present, Diagnostic Casts (Procedure D0470) may be provided. (*Note: Diagnostic Casts are payable only upon authorization of orthodontic treatment.*)

Children who do not meet the Manual of Criteria requirements for orthodontic services may still be covered if services are documented as medically necessary under the Early and Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT-SS) Regulations. See the EPSDT-SS Exception on the bottom of the HLD Score Sheet and attach the required supporting documentation in addition to completing the "Conditions" section at the top of the form. Refer to the Denti-Cal Provider Handbook, Section 9: Special Programs, for clarification of qualifying factors for EPSDT-SS. The HLD must be scored or a Resubmission Turnaround Document (RTD) will be issued.

The Limited Oral Evaluation (Procedure D0140) and/or the Diagnostic Casts (Procedure D0470), do not require prior authorization from Denti-Cal, and may be billed at this time. Do not attach the HLD Score Sheet to the claim form. Please note that all other orthodontic services do require prior authorization from Denti-Cal.

# HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

**Provider**

**Patient**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Number: \_\_\_\_\_

Date: \_\_\_\_\_

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT.

**CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS**

**HLD Score**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <p>1. Cleft palate deformity (See scoring instructions for types of acceptable documentation) Indicate an 'X' if present and score no further .....</p> <p>2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist) Indicate an 'X' if present and score no further .....</p> <p>3. Deep impinging overbite <b>WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.</b> Indicate an 'X' if present and score no further .....</p> <p>4. Crossbite of individual anterior teeth <b>WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT</b> Indicate an 'X' if present and score no further .....</p> <p>5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) Indicate an 'X' if present and score no further .....</p> <p>6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Indicate an 'X' if present and score no further.....</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|

**THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY**

- |                                                                               |                   |
|-------------------------------------------------------------------------------|-------------------|
| 6B. Overjet equal to or less than 9 mm .....                                  | _____             |
| 7. Overbite in mm .....                                                       | _____             |
| 8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm ..... | _____ x 5 = _____ |
| 9. Open bite in mm .....                                                      | _____ x 4 = _____ |

**IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.**

- |                                                                                                                                                              |               |          |             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------|-------------|
| 10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars)                                                                | _____         | _____    | x 3 = _____ |
|                                                                                                                                                              | tooth numbers | total    |             |
| 11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE)                                                                                       | _____         | _____    | x 5 = _____ |
|                                                                                                                                                              | maxilla       | mandible | total       |
| 12. Labio-Lingual spread in mm.....                                                                                                                          |               |          |             |
| 13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite)..... | Score 4 _____ |          |             |

**TOTAL SCORE:** \_\_\_\_\_

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT-SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

**EPSDT-SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE)

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <ul style="list-style-type: none"> <li>a) Principal diagnosis and significant associated diagnosis; and</li> <li>b) Prognosis; and</li> <li>c) Date of onset of the illness or condition and etiology if known; and</li> <li>d) Clinical significance or functional impairment caused by the illness or condition; and</li> <li>e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and</li> <li>f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and</li> <li>g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and</li> <li>h) Any other documentation which may assist the Department in making the required determinations.</li> </ul> | <p><b>DO NOT WRITE IN THIS AREA.</b></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|

## HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel. Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
- 6A **Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)
- 6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.
7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)
8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).
9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.
13. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERAL CROSSBITE.**

## The 2nd Step...

- *If the beneficiary qualifies for orthodontia under the guidelines of the HLD Index Score Sheet, you may provide the next step; Diagnostic Casts:*

D0470 = Diagnostic Casts



## Orthodontia Program Diagnostic Casts

1. Are a benefit once for each *phase* of orthodontic treatment
2. Will *not* be returned by Denti-Cal
3. Are payable *only* upon authorization of the orthodontic treatment plan



## Orthodontia Program Diagnostic Casts

### Submit Casts:

- That are properly trimmed & free of voids
- Be sure to mark centric, & send a bite registration or indicate markings of occlusion
- Send *only* clean, dry casts
- Label both U & L casts clearly with patient / provider information
- Pack casts *carefully*
- *DO NOT* send TARs (or RTDs) in the same package as casts
- Send casts approx. 5 days earlier than TAR

## **Diagnostic Casts**

Diagnostic Casts (Procedure D0470) are required documentation for all handicapping malocclusion and cleft palate treatment plan requests. *Exception:* If the beneficiary has a cleft palate that is not visible on diagnostic casts, casts are not required. However, photographs or documentation from a credentialed specialist must be submitted.

Cranio-facial anomalies cases do not require the submission of diagnostic casts for treatment plan requests, but do require documentation from a credentialed specialist.

Casts must be of diagnostic quality. To meet diagnostic requirements, casts must be properly poured and adequately trimmed to allow placement into centric occlusion. No large voids or positive bubbles should be present. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

Additionally, diagnostic casts should be clearly labeled with proper identification so they can be matched with the correct TAR. This identification should clearly indicate the beneficiary's name, Client Index Number (CIN) or Benefits Identification Card (BIC) number, and the dentist's name. *If the casts are received without identification, they will be destroyed.*

Careful packaging will help ensure that the casts arrive at Denti-Cal in good condition. Denti-Cal receives many broken and damaged casts due to poor packaging, which causes processing delays. Use a box that has sufficient packaging material (such as styrofoam peanuts, shredded newspaper, bubble wrap, etc.) so that the casts will not be jarred or bumped during shipping. Also, place packaging materials between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for payment or the TAR for orthodontic treatment.

Only duplicate or second pour diagnostic casts should be sent to Denti-Cal. The casts will not be returned. Diagnostic casts of denied cases will be kept in the Denti-Cal office for 30 days following a denial and up to one year off-site to enable a request for reevaluation.

**12 118 1 00003**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.) <b>Last, First</b>			3. SEX M   F <b>X</b>			4. PATIENT BIRTHDATE MO   DAY   YR <b>mm   dd   yy</b>			5. MEDI-CAL BENEFITS ID NUMBER <b>999999999999999</b>		
6. PATIENT ADDRESS <b>Address</b>						7. PATIENT DENTAL RECORD NUMBER					
CITY, STATE <b>Address</b>						ZIP CODE <b>00000</b>			8. REFERRING PROVIDER NUMBER		
9. CHECK IF YES RADIOGRAPHS ATTACHED? HOW MANY? _____		11. CHECK IF YES ACCIDENT/INJURY? EMPLOYMENT RELATED?		13. CHECK IF YES OTHER DENTAL COVERAGE:		16. CHECK IF YES CHDP CHILD HEALTH AND DISABILITY PREVENTION?		17. CHECK IF YES CCS CALIFORNIA CHILDREN SERVICES?		18. CHECK IF YES MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	
10. YES OTHER ATTACHMENTS?		12. YES ELIGIBILITY PENDING? (SEE PROVIDER MANUAL)		15. YES RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)		18. YES MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?				X	
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.) <b>Adams, James DDS</b>				20. BILLING PROVIDER NUMBER <b>1234567891</b>				BIC Issue Date: <u>8/12/2007</u>  EVC #: <u>C1294B1539</u>			
21. MAILING ADDRESS <b>30 Center Street</b>				TELEPHONE NUMBER <b>xxx xxx-xxxx</b>							
CITY, STATE <b>Anytown, CA</b>				ZIP CODE <b>95814</b>							
22. PLACE OF SERVICE OFFICE   HOME   CLINIC   SNF   ICF   HOSPITAL IN-PATIENT   HOSPITAL OUT-PATIENT   OTHER (PLEASE SPECIFY) <b>X</b>   2   3   4   5   6   7   8											

EXAMINATION AND TREATMENT											
26. TOOTH/MLTR. 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 Limited Oral Evaluation	04 02 12		D0140	50.00	1234567899				
		2 Diagnostic Casts	04 02 12		D0470	90.00	1234567899				
		3									
		4									
		5									
		6									
		7									
		8									
		9									
		10									

34. COMMENTS						35. TOTAL FEE CHARGED <b>140.00</b>	
						36. PATIENT SHARE-OF-COST AMOUNT	
39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. 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.						37. OTHER COVERAGE AMOUNT	
						38. DATE BILLED <b>04 02 12</b>	

**X** Mary Smith 04 02 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.



# The 3rd Step...

1. Submit a claim for the Exam &/or Diagnostic Casts
2. Complete a TAR for the full orthodontic treatment plan
3. Attach the HLD Index Score Sheet to the *TAR*
4. Send claim & TAR *together* in the document mailing envelope
5. Send *properly packed* Diagnostic Casts separately



## **Treatment Plan Authorization**

The Treatment Authorization Request (TAR) for orthodontic services must include the complete orthodontic treatment plan: *Comprehensive Orthodontic Treatment of the Adolescent Dentition* (Procedure D8080), *Periodic Orthodontic Treatment Visits* (Procedure D8670), and *Orthodontic Retention* (Procedure D8680). Note: Cranio-facial anomalies cases may request *Pre-Orthodontic Treatment Visits* (Procedure D8660 – maximum of 6).

Include with the authorization request any necessary radiographs, such as a full mouth series (Procedure D0210) or panoramic film (Procedure D0330), and cephalometric head film and tracings (Procedure D0340). Indicate in the "quantity" field of the TAR form, the number of visits for active treatment (Procedure D8670) depending on the type of case and the phase of dentition. Also, indicate the “case type” and “phase of dentition” in the comments section (box 34). Use usual, customary, and reasonable (UCR) fees times the quantity to ensure accurate calculation of the Notice of Authorization (NOA.)

Authorizations issued prior to the implementation of CDT-4 procedure codes will be honored until completion. Any changes to the original treatment plan will require a new TAR utilizing the CDT procedure codes.

Attach the HLD Score Sheet to the TAR and send it to the address printed on the form. Diagnostic Casts should be properly packed and boxed, and sent separately to the same address. Sending the casts approximately five days prior to sending the TAR will insure more expeditious handling at Denti-Cal. Submission of the HLD Score Sheet and diagnostic casts (or documentation from a credentialed specialist) are required documentation to substantiate the treatment plan request.

The Denti-Cal orthodontic consultant will evaluate the HLD Score Sheet and diagnostic casts or documentation together, to determine if the case qualifies for treatment under the Denti-Cal guidelines for orthodontic services.



## Reevaluation of the Notice of Authorization (NOA)

Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Denti-Cal on or before the expiration date (within 180 days).

There are no reevaluations on "exploded" NOAs. An explanation of the term "exploded" NOAs is as follows: The TAR will include all requested orthodontic treatments, but when Denti-Cal sends the NOAs, they will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- The first NOA will include the Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080) along with any radiographs that were requested on the original TAR.
- The remaining Treatment Visit NOAs (Procedure D8670) will be sent once per quarter, over the course of treatment.
- Then the orthodontic retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment.

# Reevaluation

- May be requested on a denied NOA for the Orthodontic Treatment Plan only**
- Check the 'Reevaluation Box'**
- Must be received by Denti-Cal on or before the 'expiration date'**
- Do submit HLD / additional documentation**
- Do not sign the NOA**
- NOA may only be submitted for reevaluation '1 time'**

DO NOT WRITE IN THESE AREAS

12126100013

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: 05/06/12 TO: 05/06/13

PAGE \_\_\_ OF \_\_\_



1. BENEFICIARY NAME (LAST, FRIST, M.I.)

3. SEX M F x

4. BENEFICIARY BIRTHDATE mm dd yy

5. BENEFICIARY MEDI-CAL I.D. NO.

Last, First

999999999999999

9. RADIOGRAPHS ATTACHED? CHECK IF YES

10. OTHER ATTACHMENTS? CHECK IF YES

11. ACCIDENT / INJURY? CHECK IF YES EMPLOYMENT RELATED? YES

13. OTHER DENTAL COVERAGE? CHECK IF YES 16. CHDP YES

7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 30 Center Street Anytown, CA

1234567891 (xxx) xxx-xxxx 95814

23. BIC Issue Date: \_\_\_\_\_

EVC #: \_\_\_\_\_

Table with columns: 41. DELETE, 26. TOOTH NO/106 LETTER ARCH, 27. SUR. FACES, 28. DESCRIPTION OF SERVICE, 29. DATE SERVICE PERFORMED, 30. QTY, 31. PROCEDURE NUMBER, 32. FEE, 42. ALLOWANCE, 43. ADJ. REASON CODE, 33. RENDERING PROVIDER NO.

44. DATE PROSTHESIS ORDERED

- 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 1050.00

45. PROSTHESIS LINE ITEM

46. TOTAL ALLOWANCE 790.00

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

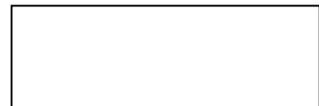
ORIGINAL SIGNATURE REQUIRED

DATE

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

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.



## Orthodontic Treatment Procedures

Payment for Procedure D8670 will be made once per calendar quarter per provider for the active phase of orthodontic treatment. A calendar quarter is defined as: January – March, April – June, July – September, and October – December. Submit one NOA containing *only one* date of service for each quarter of treatment (regardless of the number of actual treatment visits within that quarter.) Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080.)

The active phase of orthodontic treatment will be authorized for a set number of visits depending on the case type. Some treatment plans may take longer than originally anticipated due to the severity of the case. It is possible to request additional quarterly treatment visits. The request for additional treatment will require submission of a new TAR requesting; any visits left to be completed from the original authorization, plus additional visits that will complete the case, plus the retainers. If there are any outstanding NOAs from the original authorization, please attach them to the new TAR and request that they be deleted. Written documentation to justify the need for additional orthodontic treatment and progress photos must be submitted with the new TAR.

When the new TAR is authorized by Denti-Cal, a series of NOAs confirming the authorization will be mailed. The NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. Use the *new* NOAs for billing purposes. Each quarter when services are provided, submit one NOA to Denti-Cal for payment. Bill only one adjustment per NOA. Before submitting the NOA to Denti-Cal, indicate the date of service and sign the NOA.

If orthodontic treatment should be accomplished in less time than originally authorized, document this on the NOA for retainers and attach a progress photo when submitting for payment. Attach any unused NOAs for quarterly visits marking them for deletion.

### Time limitations for payment of NOAs are as follows:

- 100% of the Schedule of Maximum Allowances (SMA), when received no later than 6 months from the end of the month in which the service was performed.
- 75% of the SMA when received no later than 7 to 9 months from the end of the month in which the service was performed.
- 50% of the SMA when received no later than 10 to 12 months from the end of the month in which the service was performed

Notices of Authorization for payment will be processed in accordance with general Denti-Cal billing policies and criteria requirements for orthodontic services. **Please remember that authorization does not guarantee payment. Payment is always subject to beneficiary eligibility.**

DO NOT WRITE IN THIS AREA

12126100013

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: 05/06/12 TO: 05/06/13

PAGE OF

1. BENEFICIARY NAME (LAST, FIRST, M.I.) Last, First 3. SEX M F x 4. BENEFICIARY BIRTHDATE mm dd yy 5. BENEFICIARY MEDI-CAL I.D. NO. 9999999999999

Adams, James, DDS 1234567891 30 Center Street Anytown, CA 95814 BIC Issue Date: EVC #: 23.

Table with columns: 41. DRUG, 26. ICD-9-CM PROCEDURE, 27. ICD-9-CM PROCEDURE, 28. DESCRIPTION OF SERVICE, 29. DATE SERVICE PERFORMED, 30. QTY, 31. PROCEDURE NUMBER, 32. FEE, 42. ALLOWANCE, 43. ADJ. REASON CODE, 33. RENDERING PROVIDER NO.

44. DATE PROSTHESIS ORDERED, 45. PROSTHESIS LINE ITEM, 35. TOTAL FEE CHARGED 1050.00, 46. TOTAL ALLOWANCE 790.00, 36. BENEFICIARY SHARE-OF-COST AMOUNT, 37. OTHER COVERAGE AMOUNT, 38. DATE BILLED

39. TREATMENT COMPLETED - PAYMENT REQUESTED. THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE, ACCURATE, AND COMPLETE...

NOTICE OF AUTHORIZATION. FILL IN SHADED AREA AS APPLICABLE. SIGN AND RETURN FOR PAYMENT. MULTIPLE - PAGE NOs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION.

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.

DO NOT WRITE IN THIS AREA

12127100001

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NOTICE OF AUTHORIZATION

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FROM: 05/06/12 TO: 05/06/13

PAGE OF

1. BENEFICIARY NAME (LAST, FIRST, M.I.) Last, First 3. SEX M F x 4. BENEFICIARY BIRTHDATE mm dd yy 5. BENEFICIARY MEDI-CAL I.D. NO. 9999999999999

Adams, James, DDS 1234567891 30 Center Street Anytown, CA 95814 BIC Issue Date: 08/12/2007 EVC #:

Table with columns: 41. DRUG, 26. ICD-9-CM PROCEDURE, 27. ICD-9-CM PROCEDURE, 28. DESCRIPTION OF SERVICE, 29. DATE SERVICE PERFORMED, 30. QTY, 31. PROCEDURE NUMBER, 32. FEE, 42. ALLOWANCE, 43. ADJ. REASON CODE, 33. RENDERING PROVIDER NO.

44. DATE PROSTHESIS ORDERED, 45. PROSTHESIS LINE ITEM, 35. TOTAL FEE CHARGED 300.00, 46. TOTAL ALLOWANCE 210.00, 36. BENEFICIARY SHARE-OF-COST AMOUNT, 37. OTHER COVERAGE AMOUNT, 38. DATE BILLED

39. TREATMENT COMPLETED - PAYMENT REQUESTED. THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE...

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

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DO NOT WRITE IN THIS AREA

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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:

FROM: 05/06/12 TO: 05/06/13

RE-EVALUATION IS REQUESTED [ ] YES

PAGE \_\_\_ OF \_\_\_



1. BENEFICIARY NAME (LAST, FRIST, M.I.) Last, First 3. SEX M F x 4. BENEFICIARY BIRTHDATE MO DAY YR mm dd yy 5. BENEFICIARY MEDI-CAL I.D. NO. 99999999999999 9. RADIOGRAPHS ATTACHED? 10. OTHER ATTACHMENTS? 11. ACCIDENT / INJURY? 12. EMPLOYMENT RELATED? 13. OTHER DENTAL COVERAGE? 14. CHDP 15. BENEFICIARY DENTAL RECORD NO.

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

23. BIC Issue Date: 08/12/2007 EVC #: D141002110

Table with columns: 41. DELETE, 26. TOOTH NO/26 LETTER ARCH, 27. SUR. FACES, 28. DESCRIPTION OF SERVICE, 29. DATE SERVICE PERFORMED, 30. QTY, 31. PROCEDURE NUMBER, 32. FEE, 42. ALLOWANCE, 43. ADJ. REASON CODE, 33. RENDERING PROVIDER NO. Row 1: PERIODIC ORTHO TRMT VISIT, 08 05 12, 01, D8670, 300.00, 210.00, 1234567899

44. DATE PROSTHESIS ORDERED 45. PROSTHESIS LINE ITEM 35. TOTAL FEE CHARGED 300.00 46. TOTAL ALLOWANCE 210.00 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 Mary Jones 08 05 12

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

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.







## D8693 = Fixed Retainer Repair

(Rebonding or recementing; and/or repair, as required)

- \* Does not require prior authorization or documentation demonstrating medical necessity
- \* Requires an arch code
- \* A benefit for:
  - \* Beneficiaries under the age of 21
  - \* Once per provider



## Replacement Retainers

- \* A one time replacement benefit per appliance
- \* Use Procedure Code D8692
- \* Requires an arch code
- \* The need must be documented
- \* A benefit within 24 months of initial placement



## Transfer Cases

- Transferring from another Denti-Cal provider:
  1. Submit new TAR for remaining TX plan
  2. Attach letter from parent/legal guardian requesting deletion of previous provider's auth
- Transferring from a Non Denti-Cal provider:
  1. Submit new TAR for remaining TX plan
  2. Submit *original* diagnostic casts, + progress photos or progress casts



## Billing Limitations

- \* You have one year to bill Denti-Cal
- \* However;

0 to 6 months	=	100%
7 to 9 months	=	75%
10 to 12 months	=	50%
- \* Authorization **DOES NOT** guarantee payment
- \* Payment is **ALWAYS** subject to patient eligibility



## **Resubmission Turnaround Document (RTD)**

Denti-Cal reviews each orthodontic claim, TAR and NOA to ensure that all the required information is present and correct. If an item has been omitted or is incorrect, Denti-Cal will issue an RTD. The RTD is a computer-generated form sent to request missing or additional information. This information must be received before the document can be processed.

Section "A" of the RTD lists the error(s) found on the original document and indicates the time limitation for response. Section "B" of the form is used to enter the requested information. After completion, sign and date the form, detach section "B" and return it to Denti-Cal for processing. Retain section "A" of the RTD for the office records. Make certain to return the RTD promptly to Denti-Cal. **The provider has 45 days in which to respond.** If the RTD is not returned within the time indicated, Denti-Cal must deny the original document. Refer to the Provider Handbook, Section 6: Forms for complete instructions.

Specific to the orthodontic program, an RTD will be received 12 months into treatment inquiring if treatment is continuing. Respond to the RTD within the time allowed, or any further treatment will be denied. *In the case of a denial, a new TAR must be submitted* requesting a complete treatment plan. Procedures required on the new TAR are as follows:

1. Procedure D8670 (Periodic Ortho Treatment Visits x appropriate # of quarterly visits for case type requested)
2. Procedure D8680 x 1 (upper retainer)
3. Procedure D8680 x 1 (lower retainer)

**RESUBMISSION TURNAROUND DOCUMENT**

CLAIM  TAR  NOA

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



**IMPORTANT:** LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO DENTI-CAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDER HANDBOOK FOR FURTHER INFORMATION.

BILLING PROVIDER NAME ADAMS ADDRESS CITY STATE ZIP CODE <b>Adams, James, DDS</b> <b>30 Center Street</b> <b>Anytown, CA 95814</b>		MEDICAL PROVIDER NO. <b>1234567891</b>		PAGE 01 OF 01			
PATIENT NAME <b>Last, First</b>		PATIENT MEDICAL I.D. NUMBER <b>XXXXXX999D</b>	PATIENT DENTAL RECORD NO.	RTD ISSUE DATE <b>10/24/12</b>	RTD DUE DATE <b>12/08/12</b>		
AMOUNT BILLED <b>450.00</b>		DOCUMENT CONTROL NO. <b>12283170403</b>					
ITEM	INFORMATION BLOCK	CLAIM TYPE	CLAM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		39	N			99	

**A**

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

RETAIN THIS PORTION  
DETACH ALONG THIS PERFORATION

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY <b>12283170403</b>	DENTI-CAL USE ONLY DCN <b>12283170403</b> CLAIM TYPE <b>T</b> PAGE <b>01</b> PAGES <b>01</b>				CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A". <b>TAR - ORTHO</b>
BILLING PROVIDER NAME <b>Adams, James, DDS</b>	SUBMITTED INFORMATION	CLAIM TYPE	CLAM LINE	ERROR CODE	CORRECT INFORMATION
MEDICAL PROVIDER NUMBER <b>1234567891</b>	<b>N</b>	<b>39</b>	<b>N</b>	<b>99</b>	<b>A</b>
PATIENT NAME <b>Last, First</b>					
PATIENT MEDICAL I.D. NUMBER <b>XXXXXX999D</b>					
This is to certify that the corrected information 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 the form. <input checked="" type="checkbox"/> SIGNATURE _____ DATE _____ Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.					
IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.					

**B**

RETURN THIS PORTION TO: DENTI-CAL P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY <b>12283170403</b>	DENTI-CAL USE ONLY DCN <b>12283170403</b> CLAIM TYPE <b>T</b> PAGE <b>01</b> PAGES <b>01</b>				CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A". <b>TAR - ORTHO</b>
BILLING PROVIDER NAME <b>Adams, James, DDS</b>	SUBMITTED INFORMATION	CLAIM TYPE	CLAM LINE	ERROR CODE	CORRECT INFORMATION
MEDICAL PROVIDER NUMBER <b>1234567891</b>	<b>N</b>	<b>39</b>	<b>N</b>	<b>99</b>	<b>A</b>
PATIENT NAME <b>Last, First</b>					
PATIENT MEDICAL I.D. NUMBER <b>XXXXXX999D</b>					
This is to certify that the corrected information 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 the form. <input checked="" type="checkbox"/> SIGNATURE <b>Mary Smith</b> DATE <b>10/12/12</b> Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.					
IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.					

Leave Blank

**B**

RETURN THIS PORTION TO: DENTI-CAL P.O. BOX 15609, SACRAMENTO, CA 95852-0609

# Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement which accompanies each Denti-Cal payment received. The EOB lists all paid, modified and disallowed claims which have been processed during a payment cycle, as well as adjusted claims, and claims and TARs which have remained "in process" for more than 18 days. It also shows non-claims specific information, such as payable/receivable amounts and levy deductions. The EOB is an easy-to-read, comprehensive document which provides important payment information. Refer to the Provider Handbook, Section 6: Forms for a detailed explanation.

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

PROVIDER No: 1234567891  
 CHECK No: 00596352  
 DATE: 08/15/12 PAGE NO. 1 of 3

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

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	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID
<b>ADJUDICATED CLAIMS</b>										
B Last, First 99999999C 99999999C F mm/dd/yy										
C 12135100013	D0140		05/07/12	P		50.00	35.00			35.00
CLAIM TOTAL						50.00	35.00			35.00
B Last, First 99999999E 99999999E M mm/dd/yy										
C 12135100014	D0140		05/07/12	P		50.00	35.00			35.00
CLAIM TOTAL						50.00	35.00			35.00
*TOTAL ADJUDICATED CLAIMS						100.00	70.00			70.00
**PROVIDER CLAIMS TOTAL						100.00	70.00			70.00
<b>ADJUSTMENT CLAIMS</b>										
B Last, First 99999999A 99999999A M mm/dd/yy										
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C12043100009	D0140		02/02/12	A	318	-50.00	.00			.00
CLAIM TOTAL						-50.00	.00			.00
B Last, First 99999999A 99999999A M mm/dd/yy										
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C 12043100009	D0140		02/02/12	P		50.00	35.00			35.00
CLAIM TOTAL						50.00	35.00			35.00
*TOTAL ADJUSTED CLAIMS						.00	35.00			35.00
**PROVIDER CLAIMS TOTAL						50.00	35.00			35.00

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
70.00	35.00	.00	.00	.00	105.00

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

PROVIDER No: 1234567899  
 CHECK No: 00596352  
 DATE: 08/15/12 PAGE NO. 3 of 3

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

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

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

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	99999999D	99999999D	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 XRAY/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 ORTHO SEMINAR WILL BE HELD IN ANYTOWN ON 09/14/12 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 09/15/12 FROM 8:00 AM TO 12:00 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 Form (CIF)

Denti-Cal has developed a form to simplify the provider inquiry and response process. The form is called the Claim Inquiry Form (CIF). This form provides an automated, quick response to any inquiries.

The first use for the CIF is to inquire about the status of a claim or TAR. The provider will receive a written response from Denti-Cal called a Claim Inquiry Response (CIR). The second use for the CIF is to request reevaluation of a modified or denied claim or procedure that appears on the EOB. Always use a separate CIF for each inquiry. Complete all applicable areas on the CIF, including the provider number and DCN, and attach all related documentation. CIFs must be submitted within six months from the date of the EOB when requesting a reevaluation of a denied claim or procedure. Do not use a CIF to request a first-level appeal, or to request the reevaluation of a denied treatment plan on the NOA.

Inquiries using the CIF process are limited to only those reasons indicated on the form. Any other type of inquiry or request should be handled by telephone or written correspondence. Before submitting a CIF, use the toll-free line, (800) 423-0507 for any inquiries.

<b>CLAIM INQUIRY FORM</b>	
<b>IMPORTANT</b>	
Before submitting a CIF: <ul style="list-style-type: none"> <li>• Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)</li> <li>• Type or print all information</li> <li>• Use the appropriate x-ray envelope and attach to this form</li> <li>• See your Provider Handbook for detailed instructions</li> </ul> For clarification call DENTI-CAL	
DENTI-CAL CALIFORNIA MEDICAL DENTAL PROGRAM P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 Phone 800-423-0507	
BILLING PROVIDER NAME <b>Adams, James DDS</b>	MEDICAL PROVIDER NUMBER <b>1234567891</b>
BILLING ADDRESS <b>30 Center Street</b>	TELEPHONE NUMBER <b>(XXX) XXX-XXXX</b>
CITY, STATE <b>Anytown, CA</b>	ZIP CODE <b>95814</b>
USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.	
PATIENT NAME (LAST, FIRST, MI) <b>Last, First</b>	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
PATIENT MEDICAL ID NUMBER <b>999999999E</b>	DATE BILLED <b>10/08/12</b>
INQUIRY REASON - CHECK ONLY ONE BOX	
<b>CLAIM/TAR TRACER ONLY</b> Please advise status of: <input checked="" type="checkbox"/> Claim for Payment. Attach a copy of form Date of Service <b>10/3/12</b> <input type="checkbox"/> Treatment Authorization Request (TAR). Attach a copy of form.	<b>CLAIM RE-EVALUATION ONLY</b> <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) <b>Payment has not been received for services rendered on 10/3/12. Thank you</b>	
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.	FOR DENTI-CAL USE ONLY OPER. I.D. _____ ACTION CODE _____
X <b>Mary Jones</b> <b>12/18/12</b> SIGNATURE DATE SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.	BY: <b>7AW</b> DATE: <b>10 30 12</b>

CORRESPONDENCE REFERENCE NUMBER * FOR DENTI-CAL USE ONLY		
12352300336		
CLAIM INQUIRY RESPONSE		
Adams, James, DDS 30 Center Street Anytown, CA	DDS (XXX) XXX-XXXX 95814	DENTI-CAL MEDICAL DENTAL PROGRAM P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852 Phone (800) 423-0507
PATIENT NAME <b>Last, First</b>	DOCUMENT CONTROL NO.	
PATIENT MEDICAL ID NO. <b>999999999E</b>	PATIENT DENTAL RECORD NUMBER	DATE BILLED <b>10 03 12</b>
IN RESPONSE TO YOUR DENTI-CAL INQUIRY		
STATUS CODE <b>01</b>	EXPLANATION <b>CLAIM NEVER RECEIVED: PLEASE RESUBMIT</b>	
ADDITIONAL EXPLANATION		
BY: <b>7AW</b> DATE: <b>10 30 12</b>		

**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 <b>Adams, James DDS</b>	MEDI-CAL PROVIDER NUMBER <b>1234567891</b>
MAILING ADDRESS <b>30 Center Street</b>	TELEPHONE NUMBER <b>(XXX) XXX-XXXX</b>
CITY, STATE <b>Anytown, CA</b>	ZIP CODE <b>95814</b>

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

PATIENT NAME (LAST, FIRST, MI) <b>Last, First</b>	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION) <b>12033100009</b>
PATIENT MEDI-CAL I.D. NUMBER <b>999999999E</b>	PATIENT DENTAL RECORD NUMBER (OPTIONAL)
	DATE BILLED

**INQUIRY REASON - CHECK ONLY ONE BOX**

<p><b>CLAIM/TAR TRACER ONLY</b></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><b>CLAIM RE-EVALUATION ONLY</b></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)**

*Patient is now eligible for services.  
 EVC# C174860012*

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                      12/18/12  
 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 Appeal Process**

The 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 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 in order to ensure proper handling.
3. The appeal must clearly identify the claim or TAR in question and describe the disputed action.
4. Direct First Level Appeals to:

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

Denti-Cal staff (including professional review, if necessary) will review the appeal and respond in writing. Keep a copy of all documents related to the appeal.

## **JUDICIAL REMEDY**

If dissatisfied with the decision received regarding the appeal, the option of seeking judicial remedy is available. 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. Send all information / copies to uphold the request
4. Send appeals directly to Appeals address
5. Written notification will be received within 21 days
6. Last recourse with Denti-Cal

EXPLANATION OF BENEFITS										DENTI-CAL	
LINES PRECEDED BY "R" CONTAIN BENEFICIARY INFORMATION										CALIFORNIA MEDI-CAL DENTAL PROGRAM	
LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY										P.O. BOX 15609, SACRAMENTO, CA 95832-9609	
PROVIDER No <b>1234567899</b>								CHECK No <b>00596352</b>		DATE: <b>08/15/12</b> PAGE NO. <b>1</b> of <b>3</b>	
Adams, James, DDS 30 Center Street Anytown, CA 95814								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	
<b>ADJUSTMENT CLAIMS</b>											
B Last, First		999999999D		99999999D		M	mm/dd/yy				
<b>C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED</b>											
C 12043100009	D0140	02/02/12	A	318	-50.00	.00				.00	
CLAIM TOTAL						-50.00	.00			.00	
B Last, First		999999999D		99999999D		M	mm/dd/yy				
<b>C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED</b>											
C 12043100009	D0140	02/02/12	P		50.00	35.00				35.00	
CLAIM TOTAL						50.00	35.00			35.00	
<b>*TOTAL ADJUSTED CLAIMS</b>						.00	35.00			35.00	
<b>**PROVIDER CLAIMS TOTAL</b>						100.00	35.00			35.00	
CLAIMS SPECIFIC			NON CLAIMS SPECIFIC								
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT						
100.00	35.00	.00	.00	.00	35.00						

# Additional Information...

- Clarification of Case Types
- Fee Schedule
- Acronyms
- Phone #'s & Other Services
- CCS Information

## Clarification of Case Types

### Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. Submission of diagnostic casts is mandatory for payment of the casts. If malocclusion cases require further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review. Progress photos and/or documentation must be submitted when requesting additional visits.

### Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition, and again in the permanent dentition phase. Submission of the diagnostic casts is not mandatory for payment if the cleft palate cannot be demonstrated on the casts. However, photographs or documentation from a credentialed specialist must be attached. If the **primary dentition case** requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photos and documentation. If the **mixed dentition case** requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photos and documentation. If the **permanent dentition case** requires further treatment beyond 10 quarterly visits, a maximum of 5 additional quarters may be authorized upon review of progress photos and documentation. If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

### Craniofacial Anomaly Cases

Craniofacial anomalies cases may also be treated from birth in the primary dentition phase, again in the mixed dentition, and again in permanent dentition. Submission of the diagnostic casts for payment purposes and for the authorization of the treatment plan is optional. Documentation from a credentialed specialist is required for all craniofacial anomalies cases. If the **primary dentition case** requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photos and documentation. If the **mixed dentition case** requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photos and documentation. If the **permanent dentition case** requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photos and documentation. If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Note: Craniofacial Anomalies cases may require *Pre-Orthodontic Treatment Visits* (Procedure D8660 – maximum of 6) to monitor the facial growth on a quarterly schedule prior to starting orthodontic treatment. This procedure is not required if the beneficiary's dentition or skeletal growth is stable and the beneficiary is ready to start orthodontic treatment. Submit this procedure (x the number of visits requested) along with the TAR for the complete orthodontic treatment plan.

# DENTI-CAL FEE SCHEDULE FOR ORTHODONTIC SERVICES

<b>Malocclusion, Cleft Palate and Cranio-facial Anomalies Cases</b>		
		<b>Maximum Allowance</b>
<b>D0140</b>	Limited Oral Evaluation - All Case Types ( <i>Initial Orthodontic Examination and completion of the Handicapping Labio Lingual Deviation (HLD) Index California Modification Score Sheet</i> )	35.00
<b>D0470</b>	Diagnostic Casts - All Case Types	75.00
<b>D8080</b>	Comprehensive Orthodontic Treatment of the Adolescent Dentition - All Case Types ( <i>Includes workup, photos, banding &amp; materials</i> )	
	<b>Malocclusion Case – Permanent Dentition</b>	750.00
	<b>Cleft Palate Case</b> Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	925.00
	<b>Craniofacial Case</b> Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	1000.00
<b>D8660</b>	Pre-Orthodontic Treatment Visit ( <i>for Cranio-facial Anomalies Cases <u>Only</u></i> )	50.00
<b>D8670</b>	Periodic Orthodontic Treatment Visits - All Case Types	
	<b>Malocclusion Case</b> (8 quarterly visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	70.00
	<b>Cleft Palate Case</b> <u>Primary Dentition</u> (4 quarterly visits maximum – Up to 2 additional quarters may be authorized after initial phase of treatment)	50.00
	<u>Mixed Dentition</u> (5 quarterly visits maximum – Up to 3 additional quarters may be authorized after initial phase of treatment)	50.00
	<u>Permanent Dentition</u> (10 quarterly visits maximum – Up to 5 additional quarters may be authorized after initial phase of treatment)	100.00

<b>Cranio-facial Case</b>		
	<u>Primary Dentition</u> (4 quarterly visits maximum – Up to 2 additional quarters may be authorized after initial phase of treatment)	50.00
	<u>Mixed Dentition</u> (5 quarterly visits maximum – Up to 3 quarters may be authorized after initial phase of treatment)	50.00
	<u>Permanent Dentition</u> (8 visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	100.00
<b>D8680</b>	Orthodontic Retention - All Case Types <i>(Includes retainers &amp; all adjustments)</i>	244.00
<b>D8999</b>	Band Removal <i>(per arch – no further treatment being provided)</i> Not a benefit to the original provider, requires documentation.	50.00

## MOST COMMONLY USED ACRONYMS

<b>TAR/CLAIM FORM</b>	Treatment Authorization Request/Claim Form
<b>NOA</b>	Notice of Authorization
<b>CIF</b>	Claim Inquiry Form
<b>RTD</b>	Resubmission Turnaround Document
<b>EOB</b>	Explanation of Benefits
<b>HLD INDEX</b>	Handicapping Labio-Lingual Deviation Index California Modification Score Sheet
<b>NPI #</b>	National Provider Identifier Number
<b>PIN</b>	Personal Identification Number
<b>CIN</b>	Client Index Number
<b>BIC</b>	Benefits Identification Card
<b>EVC #</b>	Eligibility Verification Confirmation Number
<b>AEVS</b>	Automated Eligibility Verification System
<b>POS</b>	Point of Service Device
<b>SOC</b>	Share of Cost/Spend Down
<b>CCS</b>	California Children's Services

# Important Phone Numbers & Websites for Denti-Cal Providers



<b>PROVIDER TOLL-FREE LINE</b>	<b>800-423-0507</b>
<b>BENEFICIARY TOLL-FREE LINE</b>	<b>800-322-6384</b>
<b>A.E.V.S.</b> <i>(to verify beneficiary eligibility)</i>	<b>800-456-2387</b>
<b>A.E.V.S. HELP DESK</b> <b>(Medi-Cal)</b>	<b>800-541-5555</b>
<b>P.O.S. / INTERNET HELP DESK</b>	<b>800-541-5555</b>
<b>MEDI-CAL WEBSITE</b> <i>(to verify beneficiary eligibility)</i>	<b><a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a></b>
<b>DENTI-CAL WEBSITE</b>	<b><a href="http://www.denti-cal.ca.gov">www.denti-cal.ca.gov</a></b>
<b>DENTI-CAL FORMS (FAX #)</b>	<b>877-401-7534</b>

## **SPECIAL CASES**

### **California Children's Services (CCS)**

The California Children's Services (CCS) program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition.

All CCS dental providers must be enrolled and active, in the California Medi-Cal Dental Program (Denti-Cal) to receive payment for treating CCS-eligible beneficiaries.

#### **CCS Eligibility**

CCS-only, CCS/Healthy Families (HF), and CCS/Medi-Cal beneficiaries are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the Point of Service (POS) Network. For additional information about eligibility, refer to the Denti-Cal Provider Handbook, Section 9: Special Programs.

A beneficiary's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treatment. When the beneficiary changes from the CCS/Medi-Cal program to the CCS-only or CCS/HF program, providers must obtain a *Service Authorization Request (SAR)* from CCS, which is explained later in this section.

#### **Existing Authorizations From the CCS Program**

If a provider has a valid authorization that was issued by the CCS program, these authorizations will be honored through their expiration date, or through the current phase of orthodontic treatment by the same provider. Continue using the same processing guidelines that were in place when the current phase of treatment was authorized. Any further treatment must be authorized by CCS and/or Denti-Cal.

### **Processing Guidelines**

#### **CCS/Medi-Cal**

The CCS program will no longer issue authorizations for CCS/Medi-Cal beneficiaries. These beneficiaries will be subject to the treatment prior authorization guidelines and scope of benefits as defined in the Denti-Cal Provider Handbook. All claims, TARs, and associated documents are to be sent directly to Denti-Cal.

CCS/Medi-Cal beneficiaries requiring orthodontic services beyond the scope of the Denti-Cal program, may qualify for the Early and Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT-SS) program. Prior authorization and documentation are required for these services and will be determined based on medical necessity.

The provider must contact CCS for CCS-only eligibility if a beneficiary is no longer eligible for Medi-Cal.

### **CCS-only and CCS/Healthy Families (HF)**

The following is an explanation of the CCS Service Authorization Request (SAR) process, the System-Generated SAR process, Service Code Groupings (SCG), and a list of related CDT-4 procedure codes.

#### **Service Authorization Request (SAR) Process**

CCS-only and CCS/HF eligible beneficiaries will require a Service Authorization Request (SAR) from the CCS program for orthodontic treatment. A SAR must be obtained from CCS before diagnostic and treatment services are provided. CCS does not pay for services rendered prior to the date of referral.

The *CCS Dental And Orthodontic SAR form (DHS 4516)* may be used to refer a beneficiary to the CCS program, and/or may be used by the dental office to request services for a beneficiary's CCS-eligible condition. (In the case of an emergency, the orthodontist may provide treatment, but must submit the SAR to the CCS office by the next business day). This form may be downloaded from The California Department of Health Services website at:

<http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4516.pdf>.

Instructions on how to complete this form are located on the back of the form. Orthodontic providers should use only the CDT-4 procedure codes found in the Denti-Cal Provider Handbook instead of medical procedure codes. The SAR may be faxed or mailed to the appropriate CCS county/regional office (see example of the CCS Dental And Orthodontic Client SAR form at the end of this section).

## **System-Generated SAR Process**

If the requested services are medically necessary, the CCS program will determine the 'scope of benefits' and return a *system-generated SAR* to the dental office. The system-generated SAR is sent by mail only, and will not be faxed (see example of the system-generated SAR form at the end of this section).

The SAR will list the Service Code Groupings number and/or individual CDT-4 procedure codes. The SAR will provide the CCS authorization **begin date** and **end date**. SAR's for orthodontic treatment are usually issued for up to one year. The SAR is not transferable between providers. Each provider who wishes to treat a CCS-only or CCS/HF beneficiary must submit their own Dental And Orthodontic Client SAR form and receive a system-generated SAR from CCS.

After receiving the system-generated SAR, providers are to refer to the Denti-Cal Provider Handbook to determine if a TAR is required. Orthodontists must follow the Denti-Cal policies and procedures to provide orthodontic services that are within the CCS authorized scope of benefits.

It is not necessary for the dental office to attach a copy of the CCS SAR to Denti-Cal claims and TARs. CCS will electronically transmit the SAR to Denti-Cal, which must be received before services can be paid or authorized.

When providers receive the system-generated SAR from CCS, they may conduct the orthodontic examination (which includes completion of the HLD Index Score Sheet) following the guidelines described in this packet.

If CCS-only or CCS/HF beneficiaries require services beyond the scope of the Denti-Cal program, they may qualify for "Non Medi-Cal Benefits." Providers will submit documentation directly to CCS, and will continue to use the CMS-1500 claim forms for these services.

## **Service Code Groupings (SCG)**

An approved SAR will list the SCGs and/or individual procedure codes based on the provider's requested treatment plan and the beneficiary's medical condition. There are 18 SCGs which are grouped by treatment plans and procedure codes to assist the CCS program in determining services based on the beneficiary's CCS-eligible medical condition. SCGs related to orthodontic services are listed in this section. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from CCS. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Denti-Cal Provider Handbook, Section 5: Manual of Criteria.

*A CCS SAR with an SCG or individual procedure code is only an authorization for the ‘scope of benefits.’ All Denti-Cal policies, procedures, and requirements will apply to services authorized by a CCS SAR. Providers must refer to the Denti-Cal Provider Handbook prior to treating a CCS-only and CCS/HF beneficiary.*

Following is the SCGs list for orthodontic services. For a complete listing of all SCGs, refer to the Denti-Cal Provider Handbook, Section 9: Special Programs.

**CCS-only and CCS/HF Service Code Groupings for Orthodontic Services**

**SCG 02 – Orthodontic Services for Medically Handicapping Malocclusion**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

**SCG 03 – Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

**SCG 04 – Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

**SCG 05 – Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

**SCG 06 – Primary Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

**SCG 07 – Mixed Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

**SCG 08 – Permanent Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

**CCS-only and CCS/HF Procedure Code Listing for Orthodontic Services**

Denti-Cal criteria applies to all procedure codes, as do all Denti-Cal policies, procedures, and requirements. CCS-only and CCS/HF have *additional benefits and modifications based on frequency and age limitations*. Providers may request SAR authorizations for SCGs listed, or for additional procedure codes not listed in this table, refer to the Denti-Cal Provider Handbook.

<b>Procedure Code</b>	<b>Denti-Cal Procedure Code Description</b>	<b>Service Code Grouping</b>	<b><i>Additional Criteria for CCS-only and CCS/HF Benefits</i></b>
<b>D0210</b>	Intraoral, Complete Series (including bitewings)	2, 3, 4, 5, 6, 7, 8	Allowed for final records (or procedure code D0330) for orthodontic treatment
<b>D0330</b>	Panoramic Film	2, 3, 4, 5, 6, 7, 8	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
<b>D0340</b>	Cephalometric Film	2, 3, 4, 5, 6, 7, 8	Allowed for final records for orthodontic treatment
<b>D0350</b>	Oral/facial Images (including intra & extraoral images)	2, 3, 4, 5, 6, 7, 8	A benefit for final records for orthodontic treatment
<b>D0470</b>	Diagnostic Casts	2, 3, 4, 5, 6, 7, 8	One additional benefit for final records

Further information regarding the CCS program may be found in the Provider Handbook, Section 9: Special Programs.

# Example of the CCS SAR used by providers to request authorization from CCS (1 of 2 pages)

State of California—Health and Human Services Agency

Department of Health Care Services  
California Children's Services (CCS)

## CCS DENTAL AND ORTHODONTIC CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information			
1. Date of request	2. Provider name	3. Denti-Cal provider number	
4. Address (number, street)		City	State      ZIP code
5. Contact person	6. Contact telephone number (      )	7. Contact fax number (      )	

Client Information			
8. Client name—last		first	middle
9. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Date of birth (mm/dd/yy)	11. CCS case number	12. Contact phone number (      )
13. Residence address (number, street) (DO NOT USE P.O. BOX)		City	State      ZIP code
14. Mailing address (if different) (number, street, P.O. box number)		City	State      ZIP code
15. County of residence	16. Language spoken	17. Name of parent/legal guardian	
18. Mother's first name	19. Primary care physician (if known)	20. Primary care physician telephone number (      )	

Insurance Information	
21. a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, send TAR directly to Denti-Cal	21. b. If no, Client Index Number (CIN)
22. Enrolled in Healthy Families? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of plan
23. Enrolled in commercial dental insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of plan

Requested Services					
24. Service Authorization Request for (check one) <input type="checkbox"/> a. CCS established client <input type="checkbox"/> b. CCS orthodontics					
25. Tooth Number or Letter Arch	26. Surfaces	27. Description of Service (Including X-rays, prophylaxis, etc.)	28. Quantity	29. Procedure Number	30. Fee

31. Is this a CCS supplemental services request <input type="checkbox"/> Yes <input type="checkbox"/> No	32. Other documentation attached <input type="checkbox"/> Yes
33. Comments	

This is to certify that to the best of my knowledge, the information contained above and any attachments provided is true, accurate, and complete and the requested services are necessary to the health of the patient. The provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on page two of this form.

34. Signature of dental provider or authorized designee	35. Date
---------------------------------------------------------	----------

# Example of the CCS SAR used by providers to request authorization from CCS

## (2 of 2 pages)

### Instructions

1. Date of the request: Date the request is being made.

#### Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.  
3. Denti-Cal provider number: Enter Denti-Cal billing number (no group numbers).  
4. Address: Enter the requesting provider's address.  
5. Contact person: Enter the name of the person who can be contacted regarding the request, all authorizations should be addressed to the contact person.  
6. Contact telephone number: Enter the phone number of the contact person.  
7. Contact fax number: Enter the fax number for the provider's office or contact person.

#### Client Information

8. Client name: Enter the client's name—last, first, and middle.  
9. Gender: Check the appropriate box.  
10. Date of birth: Enter the client's date of birth.  
11. CCS case number: Enter the client's CCS number. If not known, leave blank.  
12. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.  
13. Residence address: Enter the address of the client. Do not use a P.O. Box number.  
14. Mailing address: Enter the mailing address if it is different than number 13.  
15. County of residence: Enter residential county of the client.  
16. Language spoken: Enter the client's language spoken.  
17. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.  
18. Mother's first name: Enter the client's mother's first name.  
19. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).  
20. Primary care physician telephone number: Enter the client's primary care physician phone number.

#### Insurance Information

21. a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, do not send this SAR to CCS, send a TAR directly to Denti-Cal.  
b. If the answer is no, enter the Client Index Number (CIN).  
22. Enrolled in Healthy Families? Mark the appropriate box. If the answer is yes, enter the name of the plan.  
23. Enrolled in a commercial dental insurance plan? Mark the appropriate box. If the answer is yes, enter the name of the commercial dental insurance plan.

#### Requested Services

24. a. CCS established client: Check if requesting approval for an established CCS client.  
b. CCS Orthodontics: Check if requesting approval for orthodontic services.  
25. Tooth number or letter, arch, quadrant: Enter the universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use arch codes U (upper), L (lower). Use quadrant codes UR (upper right), UL (upper left), LR (lower right), and LL (lower left).  
26. Tooth surfaces: Use M (mesial), D (distal), O (occlusal), I (incisal), L (lingual or palatal), B (buccal), and F (facial).  
27. Description of service: Furnish a brief description for each service. Standard abbreviations are acceptable.  
28. Quantity: For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (procedure 111), units for prosthetic procedures (procedure 716), or number of pins (procedure 648).  
29. Procedure numbers: Use a Denti-Cal three-digit, state-approved four-digit, or state-approved five-digit code for each service. NOTE: Do not mix different types of codes when completing a claim or TAR form.  
30. Fee: Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.  
31. Check yes or no box if this is a CCS Supplemental Services Request.  
32. Check the box if there is other documentation attached.  
33. Comments: Enter any additional comments.

#### Signature

34. Signature of dental provider: Form must be signed by the dentist, orthodontist, or authorized representative.  
35. Date: Enter the date the request is signed.

# Example of the system-generated SAR issued by CCS to the dental office

**CONFIDENTIAL**

SAR#

XXXXXXXX COUNTY CCS OR REGIONAL OFFICE  
 CALIFORNIA CHILDREN'S SERVICES (CCS)  
 ADDRESS 1  
 ADDRESS 2  
 CITY, ST ZIP  
 TELEPHONE:

**AUTHORIZATION FOR SERVICES**

Authorization is for services and effective dates indicated below, in accordance with CCS program policies and fee schedule. Authorization for additional services not listed below must be requested in advance. By providing these authorized services, I agree to accept payment from the CCS program as payment in full. If you have a Service Code Grouping (SCG) authorization, please check your Denti-cal manual for services included in the SCG.

Authorized Provider:	Facility Name Line 1 Line 2 Line 3 City, St Zip	Provider No: 9999999999 Telephone: (999)999-9999
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**CCS CLIENT INFORMATION**

Client Name:	Name, Client	Client Index Number:	99999999A9
Parent/Guardian:	Mr. and Mrs. Etc.	Medi-Cal Number #:	99999999999999
Address:	Line 1	CCS Case Number:	9999999
	Line 2	Date of Birth:	9/99/9999
	City, State Zip	Telephone:	(999) 999-9999

**AUTHORIZATION INFORMATION**

Effective Dates: 11/03/2008 through 11/30/2008

**CCS AUTHORIZED SERVICES**

<u>&lt;SERVICE CODE&gt; or &lt;SCG&gt;</u>	<u>&lt; SERVICE CODE DESCRIPTION&gt;</u>	<u>&lt;QUANTITY&gt;</u>

**SPECIAL INSTRUCTIONS**

<SPECIAL INSTRUCTIONS>

Please refer to the Denti-Cal manual for billing instructions. Thank you for your continued participation in the California Children's Services program.

Issued By: NAME, USER (XXXXXX COUNTY OR REGIONAL OFFICE)      Date Authorized: 12/01/2012

SAR#:

Dental SAR rules

- 1) Quantity should not display for service code groupings
- 2) The Authorized Provider name and address fields should fit into a standard window envelope
- 3) The Parent/Guardian name and address default from the primary addressee from patient registration



# 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 Orthodontic 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



# ORTHODONTIC 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 and Certification 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 Orthodontic Forms and Criteria 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 Orthodontic 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: \_\_\_\_\_