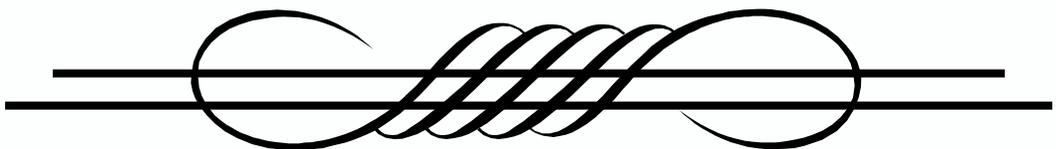


*THE  
DENTI-CAL  
WORKSHOP*



Revised 6/20/12





# Denti-Cal

California Medi-Cal Dental Program

Dear Denti-Cal Provider and Staff:

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

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

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

Sincerely,

Arbie Melvin  
Director, Customer Service  
Medi-Cal Dental Program

# **What's Happening Today**

**8:30 AM to 3:30 PM**

## **Introduction and Housekeeping**

Location of restrooms and telephones

## **Overview of Denti-Cal**

The key players

## **Provider Enrollment**

### **Eligibility**

ID cards and aid codes

Verifying identity

## **Review of Criteria**

Highlights of the most frequently performed procedures

***LUNCH - 1 hour***

## **Continue Review of Criteria**

## **Forms Used in the Billing Process**

Treatment Authorization Request (TAR)/Claim Form

Notice of Authorization (NOA)

Resubmission Turnaround Document (RTD)

Explanation of Benefits (EOB)

Claim Inquiry Form (CIF)

## **Question and Answer Period**

## **Last Minute Details**

Credits for continuing education

Completion of the evaluation form

***OK, LET'S FIND OUT WHAT YOU ALREADY KNOW  
AND WHAT YOU LEARNED TODAY!!!***

	<b><u>BEFORE</u></b>	<b><u>AFTER</u></b>
1. Only billing providers need to be enrolled in the Denti-Cal program.	T/F	T/F
2. Call the Automated Eligibility Verification System (AEVS) for treatment history <u>AND</u> patient eligibility information.	T/F	T/F
3. Possession of a Benefits Identification Card (BIC) guarantees a patient's eligibility.	T/F	T/F
4. The FRADS list includes preventive procedures.	T/F	T/F
5. A Periodic Oral Evaluation is a benefit twice a year for all beneficiaries.	T/F	T/F
6. Extractions are a benefit under FRADS.	T/F	T/F
7. Laboratory- processed Crowns are a benefit for anterior teeth only.	T/F	T/F
8. When sending a prior authorization for Scaling and Root Planing, submit the request by quadrants.	T/F	T/F
9. A Resin Base partial denture must oppose a full denture.	T/F	T/F
10. Always send radiographs for routine Extractions (D7111 & D7140).	T/F	T/F
11. You have 6 months from the latest date of service on a claim to submit the claim and receive payment at the 100% level.	T/F	T/F
12. The Notice of Authorization guarantees eligibility for 180 days.	T/F	T/F
13. For reevaluation of a denied procedure on a claim, Denti-Cal must receive the Claim Inquiry Form (CIF) within 60 days of the date the check was issued.	T/F	T/F

# The Denti-Cal Website

www.denti-cal.ca.gov

Providers

Beneficiaries

Most Popular Links

What's New

Important Reminders

The screenshot shows the Denti-Cal website interface. At the top, there is a navigation bar with links for Home, Providers, Beneficiaries, Outreach, Publications, HIPAA, NPI, Managed Care, and Statutes and Regulations. Below this is a header for the Department of Health Care Services and Denti-Cal. The main content area is divided into several sections: 'MOST POPULAR LINKS' with a list of links like 'Find a Medi-Cal Dentist', 'Provider Seminars', and 'Provider Handbooks'; 'RELATED LINKS' with links to 'Department of Health Care Services' and 'Medi-Cal Home'; 'WHAT'S NEW' with a list of recent updates such as 'HIPAA: Conversion TO 5010', 'July 2011 Bulletin', and 'Q3 2011 Seminar Schedule'; and 'IMPORTANT REMINDERS' with links to 'Q1 2011 Provider Handbook' and 'Dental Periodicity Schedule for Children'. Callouts from the surrounding text point to these sections: 'Providers' points to the navigation bar, 'Beneficiaries' points to the navigation bar, 'Most Popular Links' points to the 'MOST POPULAR LINKS' section, 'What's New' points to the 'WHAT'S NEW' section, and 'Important Reminders' points to the 'IMPORTANT REMINDERS' section.

## DDS Regional Center Consumers

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

# DDS Regional Center Consumers

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

## 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 Type 1 & 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

# Enrollment



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

## Important Phone Numbers & Websites For Denti-Cal Providers



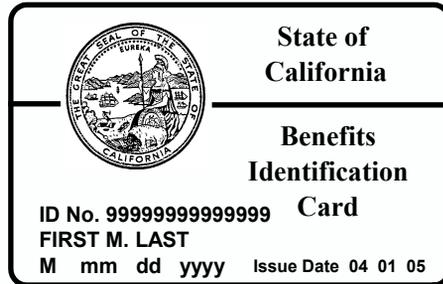
Provider Toll-Free Line	800-423-0507
Beneficiary Toll-Free Line	800-322-6384
A.E.V.S. (to verify beneficiary eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S. / Internet Help Desk	800-541-5555
Medi-Cal Website (to verify beneficiary eligibility)	<a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov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

# Eligibility



- ◇ County Dept. of Social Services *establishes* eligibility
- ◇ Eligibility information is transferred to the Dept. of Health Care Services (DHCS)
- ◇ Verify Eligibility Monthly
- ◇ Beneficiaries turning age 21
- ◇ Eligibility Verification Confirmation Number (EVC)

# *The Medi-Cal Benefits Identification Card (BIC)*



FRONT



BACK

## Eligibility



- ◇ Medi-Cal *verifies* eligibility
- ◇ 3 ways to verify eligibility
  1. *Touch Tone Telephone (A.E.V.S.)*
  2. *Internet (www.medi-cal.ca.gov)*
  3. *P.O.S. Device*
- ◇ POS/Internet Access are *free* of charge
- ◇ Request a POS Network/Internet Agreement from the POS/Internet Help Desk or Medi-Cal website

# Web Eligibility

## Screen #1

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status | [e-visit Tour](#)

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

**FEATURED**

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

**NEWSROOM** **COMING SOON** Newsroom Archives

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

**RELATED**

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

**SYSTEM STATUS ALERT**

**Outreach & Education**

eLearning Tutorials

Got a billing question or need to learn how to fill out a claim form?

Learn more

1 2 3 4 5 6

**eTAR Features**

Click to view

# Web Eligibility

## Screen #2

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status | [Login](#) | [Services Available](#) | [Enrollment Requirements](#)

Home

**Login to Medi-Cal**

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

Visit Transaction Enrollment Requirements for Medi-Cal.

Please enter your User ID:

Please enter your Password:

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

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

[Contact Medi-Cal](#) | [Medi-Cal Site Help](#) | [Medi-Cal Site Map](#)

[Back to Top](#) | [Contact Us](#) | [Site Help](#) | [Site Map](#)

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# Web Eligibility

## Screen #3

The screenshot shows the Medi-Cal website interface. At the top, there is a navigation bar with links for Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a search bar and a "GO" button. The main content area is titled "Transaction Services" and displays a list of services under the "Elig" tab. A yellow arrow points from the "Elig" tab to the "Single Subscriber" option. The "Single Subscriber" option is circled in blue. Other options include "Multiple Subscribers", "Automated Provider Services (P)", "Batch Internet Eligibility", "Medical Services Reservations (Medi-Services)", and "SOC (Spend Down) Transactions". A sidebar on the left contains a "TRANSACTIONS" menu with links for Eligibility, Claims, and eLearning.

# Web Eligibility

## Screen #4

The screenshot shows the Medi-Cal website interface for the "Eligibility Verification" form. The form is titled "Eligibility Verification" and displays a list of fields for verification. A yellow arrow points from the "Eligibility Verification" title to the "Subscriber ID" field. The fields include "Swipe Card", "Subscriber ID", "Subscriber Birth Date", "Issue Date", and "Service Date". Below the fields are "SUBMIT" and "CLEAR" buttons, and a "Recall data from last transaction" button. A note at the bottom indicates that a red asterisk indicates a required field. A sidebar on the left contains a "TRANSACTIONS" menu with links for Eligibility, Claims, and eLearning.

# Web Eligibility

## Screen #5



**Eligibility Response**

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




**TRANSACTIONS**

- Eligibility
- Claims
- eLearning

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

# Additional Information

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

- ✓ Type of Benefits
- ✓ SOC

### Aid Codes

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

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

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

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

Aid Code	Benefits	SOC	Program/Description
DA	Full	No	Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code O1, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
OC	HF services only (no Medi-Cal)	No	Access for Infants and Mothers (AIM) - Infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
OF	Full Scope	No	Five Month transitional food stamp program. This aid code is for households who are terminating their participation in the CalWORKS program without the need to re-establish food stamp eligibility.
OM	Full	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.
ON	Full	No	AE of temporary, full-scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. No time limit.

# Aid Codes

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

- Limited Services

- Restricted Services

❖ Emergency-Only services:

Require an '*Emergency Certification Statement*'

**TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM**

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL): Last, First  
 PATIENT ADDRESS: Address  
 CITY, STATE, ZIP CODE: City, State, ZIP Code  
 REFERRING PROVIDER NUMBER: 00000

PROVIDER INFORMATION:  
 NAME: ADAMS, JAMES DDS  
 ADDRESS: 30 CENTER STREET  
 CITY, STATE, ZIP CODE: ANYTOWN, CA 95814

ICD-9-CM CODE	DESCRIPTION OF SERVICE (INCLUDING DENTAL PROCEDURES AND SUPPLIES, ETC.)	DATE SERVICE PROVIDED	QUANTITY	PROCEDURE NUMBER	FEES	RECORDING PROVIDER CODE
8	Extraction of erupted tooth	03/03/12		D7140	85.00	1111111112

COMMENTS: #8 Pain & swelling - periapical abscess.

SIGNATURE: X Mary Smith, 03/03/12

# Aid Codes

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

- These procedures are *not* synonymous with the Federally Required Adult Dental Services (FRADS) procedures

- See Table 3 for the allowable procedures

# ~ Aid Code Reference Guide ~

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

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

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

# Other Insurance Coverage

- ◇ Managed Care Plans
- ◇ Other Coverage
  - ✓ Indemnity Plans
  - ✓ Denti-Cal is always secondary carrier / other coverage must be billed first

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# 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

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# Updating SOC thru the POS Network

**EXAMPLE: Patient share of cost is \$87.00**

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

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

## **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 1-800-456-AEVS (2387)
- Enter the 6 digit PIN number (not the same as the NPI number)
- Press '2' for the share of cost menu
- Press '1' to perform an update (clearance)
- Enter the patient's ID number, then the pound sign ( # )
- Enter the 2 digit month and 4 digit year of the patient'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, 2010 as 03052010)
- Enter the appropriate CDT procedure code using the 5 digit code format followed by the pound sign
- 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 patient's last name
- The first initial of the patient's 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.

# Beneficiary Dental Cap

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

## 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.

# Elimination of Optional Adult Dental Services

For beneficiaries not otherwise exempt

- Exceptions:

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

## FRADS (Table 1)

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

## Dental services for pregnant beneficiaries (Table 2)

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

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

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

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

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## **Table 1: Federally Required Adult Dental Services (FRADS)**

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

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

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

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

**Table 1: FRADS *continued***

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

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

**Table 1: FRADS *continued***

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

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

**Table 1: FRADS *continued***

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

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

**Table 2: Allowable Procedure Codes for Pregnant Beneficiaries**

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

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

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

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

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

**Table 3: Emergency Services Only *continued***

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

CDT 11-12 Code	CDT 11-12 Code Description
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral drug, single administration
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report

# Federally Required Adult Dental Services (FRADS)

## Radiographs

\* PAs or Panoramic films are allowable when they are related to a qualifying FRADS procedure

D0220 = Intraoral - periapical 1st film

D0230 = Periapical, each additional film

D0330 = Panoramic film

\* Allowable radiographs should be billed on the same claim form as the FRADS procedure

## D2920 = Recement Crown

- Prior authorization, radiographs, documentation are not required
- Not a benefit within 12 months of initial placement by the original provider
- Not a benefit within 12 months of a previous recementation
- Requires a tooth code

## D2940 = Protective Restoration

- Procedure cannot be prior authorized
- Used as a temporary restoration
- Requires a tooth code & pre-op radiograph
- A benefit once per tooth in a 6-month period
- Not a benefit on same DOS as a permanent restoration, crown or on a root canal treated tooth

## Extraction Procedures

D7111 – Coronal Remnant (deciduous tooth)

D7140 – Extraction of erupted tooth or exposed root

D7210 – Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth

D7250 – Surgical removal of residual root (cutting procedure)

D7220 – Impacted (soft tissue)

D7230 – Impacted (partial bony)

D7240 – Impacted (complete bony)

D7241 – Impacted (complete bony with surgical complications)

**B I N G O**

	D7111		D7140	
		No Radiographs Needed		

**B I N G O**

D7210				
D7220	D7230	D7240		
		Radiographs Needed		
			D7241	
				D7250

## D7210 = Surgical Extraction

- Requires reflection of a flap and removal of bone *or* sectioning of the tooth
- Written documentation is suggested if the need is not evident in the pre-op radiograph(s)
  - \* A photograph (or radiograph) may be submitted to support a surgical extraction

## Extractions

- Prior authorization is recommended for elective extractions
- Document specific condition or medical necessity for each tooth requested
- Submit radiographs depicting the entire tooth
- Prophylactic removal of 3<sup>rd</sup> molars is not a benefit

## Emergency Procedures

~ Documentation Requirements ~

Written documentation must include 3 things:

- ✓ Chief Complaint
- ✓ Diagnosis (including the tooth/area)
- ✓ Treatment Provided



## D9110 = Palliative Emergency Treatment of Dental Pain

- A "Hands-On" visit
  - A minor procedure to relieve patient of pain
  - No other services are being provided except radiographs/photos
  - Payable once per patient, per day
  - Requires written documentation
- Examples might be:
  - Perio related emergencies, removal of foreign object

## D9430 = Office Visit for Observation

*(during regular office hours) - No other services performed*

- A "Hands-Off" visit
  - For observation only
  - No other services are being provided except radiographs/photos
  - Payable once per patient, per day
  - Requires written documentation
- Examples might be:
  - Prescription, reappointing and/or referring patient

*\*\* Not a benefit for facility patients (SNF/ICF) - use D9410*

## Deep Sedation / General Anesthesia

*D9220 = First 30 minutes / D9221 = Each additional 15 minutes*

- Does not require prior authorization
- Requires documentation:
  - medical necessity or contraindication to local anesthetic agent
- Anesthesia Record must indicate:
  - Anesthetic agent used
  - Anesthesia *start & stop time* (not prep or recovery time)
- Anesthesia Permit Number must be indicated in box 34 on claim forms

## D9230 = Analgesia, Anxiolysis, Inhalation of Nitrous Oxide

- Prior authorization is not required
- A benefit for under the age of 13
  - Documentation is not required
- A benefit for patients age 13 or older only when documentation indicates an inability to respond to your attempts to perform treatment

## D9248 = Non-intravenous Conscious Sedation

- Documentation must include:
  - Specific anesthetic agent used
- Examples: Demerol, Chloral Hydrate, Fentanyl, Valium, Nembutal, etc)
- Method of administration
- Examples: Oral, patch, intramuscular or subcutaneous
- A benefit once per DOS, per provider

## D9410 = House/Extended Care Facility Call

- A benefit once per patient, per DOS (*not per facility*)
- A benefit only in conjunction with payable procedures
- Documentation must include:
  - ✓ Facility = Name, Phone #, Address (of the facility)
  - ✓ Private Residence = If patient is homebound due to a medical condition, a physician's letter must be submitted.
- Facility providers must be aware of prior authorization requirements specific to treatment of facility residents

## D9440 = Office Visit / After regularly scheduled hours

- A benefit:
  - To compensate the provider for travel to the office for emergencies outside of regular office hours
  - Once per DOS, per patient, per provider
- Documentation must include:
  - The chief complaint (tooth/area involved)
  - The time & day of the week.

## D9910 = Application of Desensitizing Medicament

This procedure *can not* be prior authorized

- A benefit:
  - Once in a 12-month period per provider
  - For permanent teeth only
- Documentation must include:
  - Tooth/teeth & the specific treatment provided

# Children, Residents of Qualifying SNFs & ICFs & DDS Regional Center Consumers

## Children & Residents of Qualifying SNFs & ICFs

- Benefits for children and residents of qualifying SNFs & ICFs did not change
- These beneficiaries may receive services for:
  - Recementations, sedative fillings, oral surgery procedures, office & facility visits
- They may also receive diagnostic, preventive, & restorative procedures as well as endodontic, periodontal & prosthodontic procedures



## DDS Consumers

- Benefits for DDS Regional Center Consumers were restored on January 1, 2012
- These beneficiaries may receive services for:
  - Recementations, sedative fillings, oral surgery procedures, office & facility visits
- They may also receive diagnostic, preventive, & restorative procedures as well as endodontic, periodontal & prosthodontic procedures



## DIAGNOSTIC D0100 – D0999

### D0150 = Comprehensive Oral Evaluation

- Allowable once per patient, per billing provider



### D0120 = Periodic Oral Evaluation

- Under the age of 21
  - A benefit 6 months after the Initial Exam & every 6 months thereafter per billing provider
- Age 21 years & older
  - A Periodic Oral Evaluation is **not** a benefit



## Radiographs / Photos

- Are considered current if taken:
  - Within 8 months for children
  - Within 14 months for adults
  - Within 36 months for Arch Integrity Films
    - Arch Integrity Films
      - Are required for ages 21 years & older
      - Are **not** required for under the age of 21
- Radiographs / Photos must include:
  - Date, patient name, provider name
  - Indicate tooth # or quadrant / arch

## Radiographs

- Must be of diagnostic quality
- Will not automatically be returned to the office
- Four or more radiographs must be mounted
- 3 or fewer may be submitted in a coin envelope
- Digitized / paper copies:
  - Maximum of 4 pages per submission
- Maximum allowance of radiographs per visit will be equivalent to the fee for a 'Complete Series'



## Do210 = Complete Series

- Must be at least:
  - 10 PAs + 2 or 4 B/Ws
  - 8 PAs + 2 Occlusal films + 2 or 4 B/Ws
  - Pano + 2 or 4 B/Ws & minimum of 2 PAs
- A benefit once in 36 months per patient, per billing provider
- Not payable when B/Ws have been paid within 6 months to same provider

## Do220 = Periapical First Film Do230 = Periapical Each Additional

- Correct billing procedure for Do220/First Film:
  - ↳ - **Periapical 1st film (Do220) & Additional films (Do230)**
  - **Bitewings (Do272 or Do274) & Additional films (Do230)**
  - **Panorex (Do330) & Additional films (Do230)**
- Maximum of 20 PAs in a 12-month period, per provider
  - Does not include PAs taken in conjunction with the Complete Series (Do210)

## Do272 = 2 Bitewing Films Do274 = 4 Bitewing Films

- A benefit:
  - Once every 6 months per billing provider
- Not a benefit:
  - For totally edentulous areas
  - Within 6 months of a Complete Series (Do210)



## Do330 = Panoramic Film

- A benefit:
  - Once in 36 months per patient, per billing provider
- Not a benefit:
  - Same date of service (DOS) as a Complete Series (Do210)



## Do350 = Photographs

- ✓ The photo should be submitted with the procedure it supports
- ✓ Photos are only payable when they are appropriate & necessary to demonstrate a clinical condition that is not apparent on the radiograph
- ✓ Maximum of 4 photos per day

# PREVENTIVE D1000 – D1999

## D1110 = Prophy (qualifying adults)

A benefit:

- age 21 and older
- once in a 12-month period per patient without prior authorization

## D1204 = Topical Fluoride (qualifying adults)

A benefit:

- age 21 and older
- paid as a full-mouth treatment
- payable once in a 12-month period per patient without prior authorization
- for caries control only
- not for desensitizing tooth/root

## D1120 = Prophy (children)

• A benefit:

- under the age of 21
- once in a 6-month period per patient without prior authorization

## D1203 = Topical Fluoride (children)

• A benefit:

- under the age of 21
- paid as a full mouth treatment
- once in a 6-month period per patient without prior authorization
- for caries control only
- not for desensitizing tooth/root

## D1206 = Topical Fluoride Varnish

Therapeutic Application for Moderate to High Caries Risk Patients

• A benefit:

- once in a 6-month period per patient *under age 21* without prior authorization
- once in a 12-month period per patient *age 21 & older* without prior authorization
- paid as a full mouth treatment
- for caries control only
- not for desensitizing tooth/root

## D1351 = SEALANTS

❖ A benefit under the age 21 for 1<sup>st</sup> & 2<sup>nd</sup> permanent molars

- No prior authorization, radiographs or documentation required
- Occlusal surface **must** be caries/restoration free
- Occlusal surface **must** be sealed
- Indicate tooth # & tooth surfaces being sealed
- Original provider is responsible for replacement for 36 months



## D1352 = Preventive Resin Restoration

In a moderate to high caries risk patient – Permanent Tooth

❖ A benefit under the age of 21 for 1<sup>st</sup> & 2<sup>nd</sup> permanent molars

- No prior authorization, radiographs or documentation required
- Once per tooth in 36 months
- Only for an active cavitated lesion in a pit or fissure that does not cross the DEJ
- Indicate tooth number & tooth surfaces being sealed
- Original provider is responsible for replacement for 36 months



## Space Maintainers

- ❖ Prior authorization is not required
- ❖ Pre-op radiographs & documentation are required indicating:
  - the missing primary molar space
  - adequate space for the erupting permanent tooth
- ❖ Not a benefit for the anterior region or for congenitally missing teeth
- ❖ Include arch/quadrant code as required
- ❖ Prefabricated crowns for restoration of abutment teeth are payable & should be billed on a separate Claim Service Line (CSL)



## D1510 = Fixed/Unilateral D1520 = Removable/Unilateral Space Maintainers

- A benefit to maintain the space for a *single* tooth
- Requires a quadrant code (*as well as the missing primary molar*)
- A benefit once per quadrant



B-PRL-TRN-011.E

## D1515 = Fixed/Bilateral D1525 = Removable/Bilateral Space Maintainers

- A benefit to maintain the space for two adjacent teeth or one missing tooth on each side
- Requires arch code (*as well as the missing primary molars*)
- A benefit once per arch
- Submit radiographs of all missing primary molars



B-PRL-TRN-011.E

## D1555 = Removal of Fixed Space Maintainers

- ✓ No prior authorization, documentation or radiographs required
- ✓ Requires a quadrant /arch code as applicable
- ✓ Not a benefit to the original provider



# RESTORATIVE D2000 – D2999

## Senate Bill – 1403

- This law applies to children age 3 and under, and the developmentally disabled person of any age who is a “Registered Consumer of the Department of Developmental Services.”
- The law states that *one* current diagnostic radiograph or photo showing caries through the DEJ on at least one tooth surface will be sufficient to allow *all* restorations and/or prefabricated crowns on the same claim or TAR.
- The requirement for arch films will be waived for prefabricated crowns on permanent teeth.



## D2140 - D2394

### Amalgam & Composite Restorations

- Prior authorization is not required
- Original provider is responsible for:
  - 12 months for primary teeth
  - 36 months for permanent teeth
  - Loss due to circumstances beyond provider's control must be documented
- Four or more restorations per patient in a 12-month period require radiographs
  - *Senate Bill 1403 exceptions apply*
  - Photos are optional

## D2140 - D2394 Amalgam & Composite Restorations

### Proper billing procedures:

- All surfaces on a single tooth restored with the same material will be considered connected when performed on the same DOS & should be requested on the same CSL
- Each non-connected restoration on the same tooth & same DOS should be billed on separate CSLs
- Separate restorations using different materials on the same tooth are allowable – *bill on 2 separate CSLs*

## D2140 - D2394

### Amalgam & Composite Restorations

- Payment is made for a tooth surface only once per date of service regardless of the number or combination of restorative materials placed on that surface

Example:                    # 3 MO - D2150  
                                      # 3 DQ - D2150

*Would be payable as #3 MOD = D2160*

## D2330 - D2335 Composite Restorations

- A proximal restoration in an anterior tooth is paid as a single surface restoration,
  - unless the involved F or L tooth structure extends to at least 1/3 the width of the clinical crown
  - Radiographs must justify the request for payment

### Examples:

#9 DFL - Paid as a single surface	D2330
#9 DFL - 1/3 Facial <u>or</u> Lingual involved	D2331
#9 DFL - 1/3 Facial <u>&amp;</u> Lingual involved	D2332

## D2390 = Composite Crown - Anterior

- Criteria is the same as other composites
- Requires at least four tooth surfaces be involved



## Laboratory Crowns

- Prior authorization is required
- Submit a PA of the tooth + Arch Integrity films
  - Longevity
  - Periodontal condition
  - Restorability
  - Reasonable occlusal plane
- A benefit for permanent teeth only
- Not a benefit for patients under 13 years of age

## Laboratory Crowns - Criteria -

### Anteriors

*Destruction of 4 or more tooth surfaces including incisal angle, or destruction of more than 50% of the clinical crown*

### Bicuspids

*3 or more tooth surfaces including 1 cusp*

### Molars

*4 or more surfaces including 2 cusps*

## Laboratory Crowns - Bicuspid & Molars -

- Posterior crowns are a benefit for age 21& over only when the tooth meets existing crown criteria & is an:
  - ✓ abutment for a removable prosthesis with cast clasps or rests
- Submit radiographs/photos depicting existing appliance

## Prefabricated Crowns - Primary Teeth -

D2930 = Stainless Steel Crown    D2932 = Resin Crown

D2933 = SS with Resin Window

- Prior authorization is not required
- Submit a pre-op radiograph \*SB -1403 Exception applies
- A benefit once in a 12-month period
- Criteria:
  - Three or more tooth surfaces or
  - Extensive two-surface interproximal preparation or
  - In conjunction with a pulpotomy

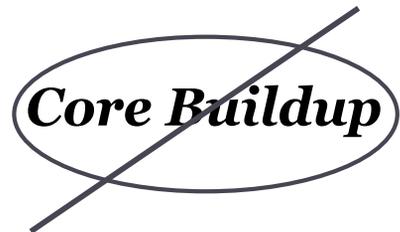
## Prefabricated Crowns - Permanent Teeth -

D2931 = Stainless Steel Crown    D2932 = Resin Crown

D2933 = SS with Resin Window

- Prior authorization is not required
- Submit a pre-op radiograph + arch films \*SB -1403 Exception applies
- A benefit once in a 36-month period
- Criteria:
  - Same tooth type criteria as laboratory crowns or
  - If used to restore an endodontically treated bicuspid or molar

## D2950 = Core Buildup



- Included in the fee for the restorative procedure (global)
- Not payable separately

**D2952 = Cast Post & Core**  
**D2954 = Prefabricated Post & Core**

- Prior authorization is not required
- Submit a PA of the tooth & Arch Films
- A benefit:
  1. When tooth has been endodontically treated,  
     and
  2. Tooth has or will have a covered crown (pre-fabricated or laboratory crown)

**ENDODONTICS D3000 – D3999**

**D3220 =  
Therapeutic Pulpotomy**

- No prior authorization, radiographs or documentation required for payment
- A benefit once per primary tooth
- For the surgical removal of the pulpal tissue of the entire pulp chamber with the aim of maintaining vitality in the root portion



**D3221= Pulpal Debridement**

- For permanent teeth (or over-retained primary tooth)
- For the INITIAL open & drain procedure
- No prior authorization, radiographs/photos, or documentation are required
- Payable once per tooth
- For relief of pain prior to conventional RCT
- Not payable with any other service on the same tooth, same DOS



**D3222 = Partial Pulpotomy  
for Apexogenesis**

~permanent tooth with incomplete root development~

- Requires prior authorization with periapical radiographs
- Requires a tooth code
- A benefit once per permanent tooth under the age of 21
- Not payable on same DOS as any other endodontic procedure

**Pulpal Therapy / Resorbable filling**

Anterior / Primary Tooth = D3230  
Posterior / Primary Tooth = D3240

- No prior authorization, radiographs/photos, documentation are required
- A benefit once per tooth
- Not payable on same DOS as a pulpotomy or pulpal debridement, same tooth

## Root Canal Therapy

Anterior = D3310 / Bicuspid = D3320 / Molar = D3330

- Prior authorization is required

### Exceptions

- Tooth has been accidentally avulsed
  - Crown fracture exposes vital pulp tissue
- 
- Submit Arch Integrity films + PA of tooth
    - Longevity
    - Periodontal condition
    - Restorability
    - Occlusal function
- 
- Final PA is not required for payment



## Root Canal Therapy



- Fee for payment includes:
  - All treatment & post-treatment radiographs
  - Temporary restoration and/or occlusal amalgam or composite seal
  - Postoperative care for 30 days

- RCT is not a benefit for 3rd molars

### Exceptions

- Tooth occupying 1st or 2nd molar position
- If an abutment to an existing fixed bridge or existing removable partial denture with cast clasps or rests

## Root Canal Retreatment

Anterior = D3346 Bicuspid = D3347 Molar = D3348

- Prior authorization is required
- Submit Arch Integrity films + PA of tooth
- Requires documentation of need if not evident in the radiographs
- Not a benefit to original provider within 12 months of initial TX
- Final PA is not required for payment



## Apexification / Recalcification / Pulpal Regeneration

- D3351 = Initial Visit
  - Prior Authorization is required
  - Submit Arch Integrity films + PA of tooth
- D3352 = Interim Medication Replacement
  - No Prior Authorization required
  - Initial visit (D3351) must be completed first
- No final PA required for payment
- A benefit once per permanent tooth under the age of 21

# PERIODONTICS D4000 – D4999

## D4249 = Clinical Crown Lengthening

- This procedure is included in the fee for a completed restorative procedure (global)
- It is not payable separately

## Periodontics - General Policies

- Prior authorization is required
  - Submit:
    - The ***definitive periodontal diagnosis***
    - Complete Periodontal Evaluation Chart
    - Current PA's of involved areas + arch films for scaling & root planing and osseous surgery procedures
    - *Photographs* are required for gingivectomy & gingivoplasty procedures
  - A benefit for age 13 years & older
- Exceptions
- Aggressive Periodontitis or Drug-induced Hyperplasia



## Scaling & Root Planing

D4341 = Four or more teeth / D4342 = Three or fewer teeth

- A benefit once per quadrant in a 24-month period
- Prior authorization requires:
  - Quadrant code
  - PA's of all involved teeth in quadrant + arch films
  - The definitive periodontal diagnosis
- Qualifying factors for each tooth:
  - A minimum of one 4mm+ pocket
  - Connective tissue attachment loss
  - At least minimal bone loss or the presence of subgingival calculus

# Example

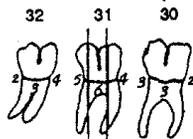
## PERIODONTAL EVALUATION CHART

Patient Name \_\_\_\_\_

Charting Date \_\_\_\_\_

**REQUIRED INFORMATION** NUMERICAL CHARTING OF POCKET DEPTHS, BONE LOSS, MOBILITIES AND TEETH TO BE EXTRACTED. CHART AT LEAST TWO NUMBERS FOR FACIAL AND TWO NUMBERS FOR LINGUAL SURFACES OF EACH TOOTH.

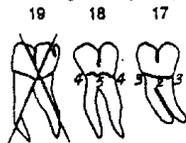
Teeth to be extracted (# 31)



EXAMPLES



Missing Teeth (# 19)



TOOTH MOBILITY (PLEASE SCORE EACH TOOTH)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

MOBILITY

NONE = 0

SLIGHT = 1

MODERATE = 2

SEVERE = 3

FACIAL

LINGUAL

LINGUAL

FACIAL

# PROSTHODONTICS/REMOVABLE D5000 – D5899

## JUSTIFICATION OF NEED FOR PROSTHESIS

### *Complete Dentures, Resin Base Partial Dentures, Cast Metal Framework Partial Dentures*

This form is to be completed by the dentist providing treatment. Both arches must be evaluated and addressed. Chart missing teeth and teeth to be extracted. Complete each section of the form. Attach this form to the submitted TAR.

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

**ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE ITEM (TYPE OR PRINT CLEARLY)**

MAXILLARY ARCH	MANDIBULAR ARCH																																																																
Appliance Requested: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD	Appliance Requested: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD																																																																
Existing Appliance: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD <input type="checkbox"/> Never had a maxillary prosthetic appliance	Existing Appliance: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD <input type="checkbox"/> Never had a mandibular prosthetic appliance																																																																
Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No Age of Appliance: _____	Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No Age of Appliance: _____																																																																
Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>**Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.</b>	Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>**Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.</b>																																																																
If lost in facility or hospital, explain circumstances: _____	If lost in facility or hospital, explain circumstances: _____																																																																
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Opposing Dentition	<input type="checkbox"/>	<input type="checkbox"/>	_____																																																														
Centric Occlusion <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate	Edentulous <input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular 1 2 3 4 5 6 7 8   9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25   24 23 22 21 20 19 18 17																																																																
Vertical Relation <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate Open ____ mm. Closed ____ mm.	<b>X Block out missing teeth    O Circle teeth to be extracted</b>																																																																

**REQUIRED FIELD FOR PARTIAL DENTURES (All Types)**

MAXILLARY ARCH	MANDIBULAR ARCH
Teeth Being Replaced: _____	Teeth Being Replaced: _____
Teeth Being Clasped: _____	Teeth Being Clasped: _____

If treatment involves retaining teeth in the arch(es), indicate treatment plan for remaining teeth (Root canals, periodontal treatment, restorative, crowns, etc.): \_\_\_\_\_

Does the patient want requested services?  No  Yes

Does health condition of the patient limit dental adaptability?  No  Yes Explain: \_\_\_\_\_

**ADDITIONAL COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CONVALESCENT CARE:** Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider Signature \_\_\_\_\_ License # \_\_\_\_\_

## Prosthodontics / Removable General Policies

- A benefit once in a 5-year period

### Exceptions:

- Catastrophic loss beyond patient control (submit a copy of an official public service agency report)
  - Surgical or traumatic loss of oral-facial anatomic structure
  - Existing prosthesis is no longer serviceable
- Authorized as a complete treatment plan only
  - Submit completed DC-054 Form for all requests



## Prosthodontics / Removable General Policies

- Fee includes all adjustments for 6 months after delivery date
- Use the laboratory order date as the DOS
- Consideration for an undeliverable appliance (80%) may be requested when documentation & a copy of the lab invoice are submitted with the NOA for payment
- *Do Not* alter approved treatment plan without prior approval

## Full Dentures

- D5110 = Maxillary / D5120 = Mandibular

### Complete Dentures

- Submit radiographs of all opposing teeth with the authorization

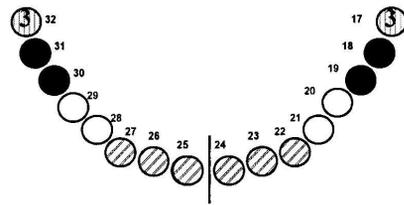
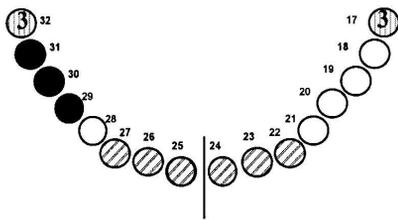
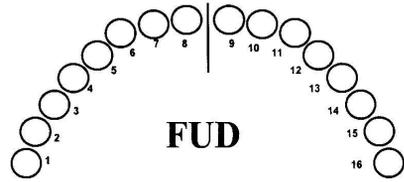
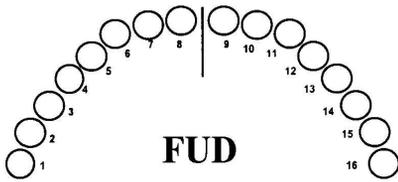
- D5130 = Maxillary / D5140 = Mandibular

### Immediate Dentures

- Submit radiographs of all remaining teeth with the authorization

# LACK OF POSTERIOR BALANCED OCCLUSION

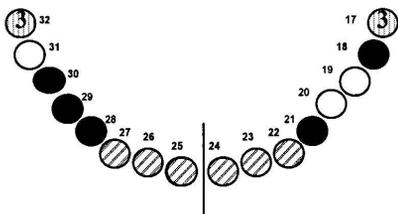
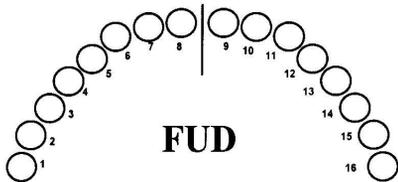
For Partial Dentures (Resin Base or Cast Metal Framework)



**3** The 1<sup>st</sup> & 2<sup>nd</sup> molars and the 2<sup>nd</sup> bicuspid are missing on the same side.

**4** All four 1<sup>st</sup> and 2<sup>nd</sup> molars are missing.

**5** Total of five posterior permanent teeth are missing (excluding 3<sup>rd</sup> molars).



**3** = 3<sup>rd</sup> molars

### 3<sup>rd</sup> Molars

- Are not counted for balanced occlusion
- May act as abutments for a partial denture

### Resin Base Partial Denture

- Does not need to oppose a complete denture
- A benefit when arch lacks posterior balanced occlusion
- A benefit when replacing a permanent anterior tooth
- Posterior teeth may be included in the partial denture when replacing an anterior tooth

### Cast Metal Framework Partial Denture

- Must oppose a complete denture
- A benefit when opposing arch lacks posterior balanced occlusion

 = Anteriors

(Rev 11-07)

## Partial Dentures Resin Base

D5211 = Maxillary    D5212 = Mandibular

- Submit arch integrity films & PAs of abutment teeth with your authorization
- A benefit to replace at least one permanent anterior tooth, or if the arch lacks posterior balanced occlusion
- Appliance may oppose natural teeth
- Fee includes:
  - All teeth, clasps & rests
  - All adjustments for 6 months from delivery date

## Partial Dentures Cast Metal Framework

D5213 = Maxillary    D5214 = Mandibular

- Submit arch integrity films & PAs of abutment teeth with your authorization
- A benefit only when opposing a full denture and the arch lacks posterior balanced occlusion
- Fee includes:
  - All teeth, clasps & rests
  - All adjustments for 6 months from delivery date

## Denture Adjustments

D5410 = Max Complete    D5411 = Mand Complete  
D5421 = Max Partial      D5422 = Mand Partial

- A benefit:
  - Twice in a 12-month period per billing provider (*per appliance*)
  - Once per arch, per DOS
- Not payable to the same provider within 6 months of:
  - Delivery of new dentures (full or partial)
  - Relines
  - Repairs

## Denture Repairs

- Require an arch code
- Each arch is a benefit twice in a 12-month period
- Includes any adjustments for 6 months to the same billing provider

## Chairside Relines

D5730 = Max Complete    D5731 = Mand Complete  
D5740 = Max Partial      D5471 = Mand Partial

- Do not require prior authorization, radiographs or documentation
- A benefit:
  - Once in a 12-month period
  - 6 months after delivery of an immediate appliance
  - 12 months after delivery of a complete appliance
- Not a benefit within 12 months of a Lab Reline

## Laboratory Relines

D5750 = Max Complete / D5751 = Mand Complete  
D5760 = Max Partial    / D5461 = Mand Partial

- Do not require prior authorization, radiographs or documentation
- A benefit:
  - Once in a 12-month period
  - 6 months after delivery of an immediate appliance
  - 12 months after delivery of a complete appliance
- Not a benefit within 12 months of a Chairside Reline
- Not a benefit for a Resin Base partial denture

## Tissue Conditioning

D5850 = Maxillary / D5851 = Mandibular

- Does not require prior authorization, radiographs or documentation
- A benefit twice in a 36-month period (*per appliance not per provider*)
- Includes all adjustments for 6 months to same provider
- Is allowable on same DOS as insertion of an immediate appliance

## D6200 – D6999 Prosthodontics – Fixed

- *A benefit only when medical conditions or employment preclude the use of a removable partial denture*
- Prior authorization is required. Submit PAs & arch films
- Patient must 1st meet the criteria for a removable partial
- Requests must be accompanied by a physician's letter or letter from case worker documenting need

## Residents of SNFs & ICFs

### Treating Patients *in* the Facility

- All services ***except diagnostic & emergency*** procedures require prior authorization
- Use ***Place Of Service 4*** or ***5***
- Submit the name, address & phone number of the facility in box 34 of TAR or claim

### Treating Facility Patients *outside* of the Facility

- All services except diagnostic & emergency procedures require prior authorization regardless of where they are being treated
- Use ***Place Of Service 4*** or ***5***
- Required documentation
  - State where the *patient is actually being treated*, and
  - Submit the name, address & phone number of the facility in Box 34 of TAR or claim

## D4910 = Periodontal Maintenance

- A benefit:
  - *Only* for beneficiaries residing in a qualifying SNF or ICF (***POS 4*** or ***5***)
  - *Only* if medically necessary
- Prior authorization, perio charting or radiographs are not required
- Considered a full-mouth treatment when performed subsequent to Root Planing (***D4341*** or ***D4342***)
- Not a benefit in the same calendar quarter as Root Planing
- Not payable to the same provider in the same calendar quarter as prophylaxis (***D1110-Adult*** or ***D1120-Child***)

# Pregnancy

## Pregnancy

*(21 years & older - full scope aid codes)*

• Allowable benefits for pregnant women, including 60 days postpartum:

- Services from Table 1
  - Any FRADS procedure
- Services from Table 2
  - Comprehensive Oral Evaluation
  - Prophy / Prophy-Fluoride
  - Periodontal procedures
  - Bitewings
  - Document 'pregnant' or 'postpartum'



## Pregnancy



• **Scaling & Root Planing (D4341 - D4342)**

- A definitive periodontal diagnosis & arch integrity films are waived
- Requires quadrant codes, PAs of all involved areas & a completed periodontal chart
- Document 'pregnant' or 'postpartum'

## Pregnancy

• Indicate 'Pregnant' or 'Postpartum' for all Aid Codes (*prior authorization requirements are waived for these beneficiaries*)

- Limited Scope Aid Codes (all ages)
  - ✓ Submit on a claim form
  - ✓ Do Not submit a TAR
- Full Scope Aid Codes (under age 21)
  - ✓ Submit on a claim form
  - ✓ Do Not submit a TAR
- Full Scope Aid Codes (age 21 & over)
  - ✓ Submit on a claim form (*resend on a CIF*)
  - ✓ Do Not submit a TAR







DO NOT WRITE IN THIS AREA

12318100124

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



NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

RE-EVALUATION IS REQUESTED [ ] YES

FROM: 11/14/12

TO: 05/13/13

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



1. BENEFICIARY NAME (LAST, FRIST, M.I.) Last, First 3. SEX M F X 4. BENEFICIARY BIRTHDATE mm dd yy 5. BENEFICIARY MEDI-CAL I.D. NO. 99999999999999 9. RADIOGRAPHS ATTACHED? 10. OTHER ATTACHMENTS? 11. ACCIDENT / INJURY? 13. OTHER DENTAL COVERAGE? 16. CHDP 7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891 30 Center Street (xxx) xxx-xxxx Anytown, CA 95814 23. BIC Issue Date: EVC #:

Table with columns: 41. DELETE, 26. TOOTH NO OR 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. Rows include Root Canal Therapy, Amalgam, Extraction - Erupted Tooth, Partial Denture - Resin Base, Scaling & Root Planing.

44. DATE PROSTHESIS ORDERED 45. PROSTHESIS LINE ITEM 35. TOTAL FEE CHARGED 1555.00 46. TOTAL ALLOWANCE 661.00

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

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

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



# Reevaluation



DO NOT WRITE IN THIS AREA

**12318100124**

**NOTICE OF AUTHORIZATION**

12318100124  
DENTI-CAL  
CALIFORNIA MEDICAL DENTAL PROGRAM  
P.O. BOX 15669  
SACRAMENTO, CALIFORNIA 95822-0669  
Phone 800-423-1607

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

RE-EVALUATION IS REQUESTED  YES

1. BENEFICIARY NAME (LAST FIRST MI)  
Last, First x | mm | dd | yy | 9999999999999999

2. ADDRESS (SEE INSTRUCTIONS)  
Adams, James, DDS  
30 Center Street  
Anytown, CA 95814

3. DENTIST IDENTIFICATION NUMBER  
1234567891  
(xxxx) xxx-xxxx

4. BIC Issue Date:  
EVC #:

30	31	32	33	34	35	36	37	38
CD	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	ICD-9 RESPONSE	ICD-9 CITY	31-Procedure Number	32 FEE	34 ALLOWANCE	35-ADJ. ALLOWANCE	36-RENDERING PROVIDER NO.
3	Root Canal Therapy	XXXXX		D3320	500.00	.00	R270	
3	Root Canal Therapy			D3330	500.00	331.00	S270	
3	O Amalgam			D2140	55.00	39.00	355C	
9	Extraction - Erupted Tooth			D7140	50.00	41.00	355C	
U	Partial Denture - Resin Base		01	D5211	400.00	250.00		
LL	Scaling & Root Planing	XXXXX		D4341	50.00	.00	074B	

46. SUBTOTAL AMOUNT  
1555.00

47. ALLOWANCE  
661.00

34. COMMENTS

35. TOTAL FEE (SHIPPED)

36. TOTAL ALLOWANCE

37. REASON FOR COST

38. DATE BILLED

39. TREATMENT COMPLETED - PAYMENT REQUESTED

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

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

DO NOT WRITE IN THIS AREA

12318100124

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



NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

RE-EVALUATION IS REQUESTED YES

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

PAGE OF



1. BENEFICIARY NAME (LAST, FRIST, M.I.) Last, First 3. SEX M F X 4. BENEFICIARY BIRTHDATE mm dd yy 5. BENEFICIARY MEDI-CAL I.D. NO. 99999999999999 9. CHECK IF RADIOGRAPHS ATTACHED? YES 10. CHECK IF OTHER ATTACHMENTS? YES 11. CHECK IF ACCIDENT / INJURY? YES 13. OTHER DENTAL COVERAGE? YES 16. CHDP YES 7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891 30 Center Street (xxx) xxx-xxxx Anytown, CA 95814 23. BIC Issue Date: EVC #:

Table with columns: 41. DELETE, 26. TOOTH NO OR 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. Rows include Complete Denture and Immediate Denture.

44. DATE PROSTHESIS ORDERED 45. PROSTHESIS LINE ITEM 35. TOTAL FEE CHARGED 1200.00 46. TOTAL ALLOWANCE 900.00

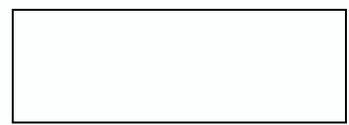
34. COMMENTS 36. BENEFICIARY SHARE-OF-COST AMOUNT 37. OTHER COVERAGE AMOUNT 38. DATE BILLED

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. 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.



# Exercise 1 - Patient Record

*(Adult beneficiary, no exemptions)*

Patient Name: First M. Last		Date of Birth: 07/09/65	
Date	Tooth #	Service Description	
9/9/12		2 PAs	25.00
9/9/12	12	Recement Crown	45.00
9/9/12	2	Extraction	65.00
9/16/12		Prophy	60.00

*Using the following form, please bill Denti-Cal for the allowable FRADS procedures.*

DENTICAL  
CALIFORNIA MEDI-CAL DENTAL PROGRAM  
P.O. BOX 15610  
SACRAMENTO, CALIFORNIA 95852-0610  
Phone 800-423-0507



# TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)		3. SEX M   F		4. PATIENT BIRTH DATE MO   DAY   YR			5. MEDICAL BENEFITS ID NUMBER				
6. PATIENT ADDRESS						7. PATIENT DENTAL RECORD NUMBER					
CITY, STATE						ZIP CODE					
9. RADIOGRAPHS ATTACHED? CHECK IF YES						11. ACCIDENT/INJURY? CHECK IF YES		13. OTHER DENTAL COVERAGE? CHECK IF YES		15. SHIP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES	
HOW MANY? _____						EMPLOYMENT RELATED? YES		11. MEDICAL DENTAL COVERAGE? YES		17. CALIFORNIA CHILDREN SERVICES? YES	
10. OTHER ATTACHMENTS? YES						12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) YES		15. RESIDENT ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) YES		18. M-F-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES	
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)						20. BILLING PROVIDER NUMBER					
21. MAILING ADDRESS						TELEPHONE NUMBER ( )					
CITY, STATE						ZIP CODE					
22. PLACE OF SERVICE											
OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT		HOSPITAL OUT-PATIENT		OTHER (PLEASE SPECIFY)		
1	2	3	4	5	6		7		8		

**Example of a Claim for Billable FRANDS Procedures**

BIC Issue Date: \_\_\_\_\_

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

EXAMINATION AND TREATMENT							
26. TOOTH/ULTR ARCH/QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NO.
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS						35. TOTAL FEE CHARGED	
						36. PATIENT SHARE OR 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	

**X** \_\_\_\_\_

SIGNATURE

DATE

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

#### 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 Form & Supplier.



# Exercise 2 - Patient Record

*(Beneficiary under the age of 21)*

Patient Name: First M. Last		Date of Birth: 01/06/98		
Date	Tooth #		Service Description	
9/9/12			Exam, 2 Bitewings, 6 PAs	80.00
9/9/12	12	MOD	Amalgam	95.00
9/9/12	13		Needs a crown (DOB decay - B cusp is undermined with decay)	

*Using the following form, please complete the TAR for prior authorization.*

DENTICAL  
CALIFORNIA MEDICAL DENTAL PROGRAM  
P.O. BOX 15610  
SACRAMENTO, CALIFORNIA 95852-0610  
Phone 800-423-0507



# TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)		3. SEX M   F	4. PATIENT BIRTHDATE MO   DAY   YR		5. MEDICAL BENEFITS NUMBER
6. PATIENT ADDRESS					7. PATIENT DENTAL RECORD NUMBER
CITY, STATE				ZIP CODE	8. REFERRING PROVIDER NUMBER
9. RADIOGRAPHS ATTACHED? CHECK IF YES	11. ACCIDENT/INJURY? CHECK IF YES	13. OTHER DENTAL COVERAGE? CHECK IF YES		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES	
HOW MANY? _____	EMPLOYMENT RELATED? YES	14. MEDICAL DENTAL COVERAGE? YES		17. CALIFORNIA CHILDREN'S SERVICES? YES	
10. OTHER ATTACHMENTS? YES	12. ELIGIBILITY BENEFITS (SEE PROVIDER MANUAL)	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)		18. MFO MAXILLOFACIAL - ORTHODONTIC SERVICES? YES	
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)			20. BILLING PROVIDER NUMBER		
21. MAILING ADDRESS			TELEPHONE NUMBER		
CITY, STATE			ZIP CODE		
22. PLACE OF SERVICE OFFICE: 1   HOME: 2   CLINIC: 3   SNF: 4   ICF: 5   HOSPITAL IN-PATIENT: 6   HOSPITAL OUT-PATIENT: 7   OTHER (PLEASE SPECIFY): 8					

Example of a TAR for a Beneficiary Under the Age of 21

BIC Issue Date: \_\_\_\_\_

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

EXAMINATION AND TREATMENT							
26. TOOTH/ROOT ARCH/QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NO.
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

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

**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 Dent-Cal Form's Supplier.

**X** \_\_\_\_\_  
SIGNATURE DATE

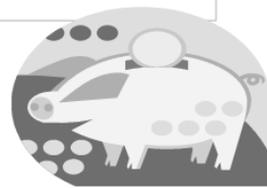
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.





# Direct Deposit

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



**EXPLANATION OF BENEFITS**

**DENTI-CAL**

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



LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

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

PROVIDER  
No **1234567891**

CHECK  
No **00596352**

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

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

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

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

B	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
---	----------------------	------------	------------	-----------------	---------	-------------	---------------	----------------	---------------	----------------	-------------

**ADJUDICATED CLAIMS**

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

**ADJUSTMENT CLAIMS**

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

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

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC		
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT
<b>101.00</b>	<b>85.00</b>			<b>186.00</b>

**EXPLANATION OF BENEFITS**

**DENTI-CAL**

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



LINES PRECEDED BY "R" CONTAIN BENEFICIARY INFORMATION

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

PROVIDER  
No 1234567899

CHECK  
No 00596352

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

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

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

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

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

**DOCUMENTS IN-PROCESS**

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

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

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

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

\*\*\*\*\*  
THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN  
ON 09/10/12 FROM 9:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507  
FOR RESERVATIONS

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

\*\*\*\*\*  
THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN  
ON 10/15/12 FROM 9:00 AM TO 4:00 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

**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>	DENTI-CAL PROVIDER NUMBER <b>1234567899</b>
MAILING ADDRESS <b>30 Center Street (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)		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
<b>INQUIRY REASON - CHECK ONLY ONE BOX</b>		
<b>CLAIM/TAR TRACER ONLY</b> Please advise status of: <input type="checkbox"/> Claim for Payment. Attach a copy of form Date of Service <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)		
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 _____ SIGNATURE DATE		
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.		

CORRESPONDENCE REFERENCE NUMBER * FOR DENTI-CAL USE ONLY
<b>12084300132</b>

**CLAIM INQUIRY RESPONSE**

<b>Adams, James, DDS</b>	<b>1234567899</b>
<b>30 Center Street</b>	<b>(XXX) XXX-XXXX</b>
<b>Anytown, CA</b>	<b>95814</b>

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

PATIENT NAME <b>Last, First</b>		DOCUMENT CONTROL NO.
PATIENT MEDI-CAL I.D. NO. <b>99999999D</b>	PATIENT DENTAL RECORD NUMBER	DATE BILLED <b>02/13/12</b>
<b>IN RESPONSE TO YOUR DENTI-CAL INQUIRY</b>		
<b>STATUS CODE</b>	<b>EXPLANATION</b>	
<b>01</b>	<b>CLAIM NEVER RECEIVED: PLEASE RESUBMIT</b>	
ADDITIONAL EXPLANATION		
BY: <b>7AW</b> DATE: <b>04/03/12</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 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>1234567899</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)		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)	
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED	

**INQUIRY REASON - CHECK ONLY ONE BOX**

<p align="center"><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 align="center"><b>CLAIM RE-EVALUATION ONLY</b></p> <p><input 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)**

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

**X** \_\_\_\_\_  
 SIGNATURE 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 \_\_\_\_\_



# First Level Appeals

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

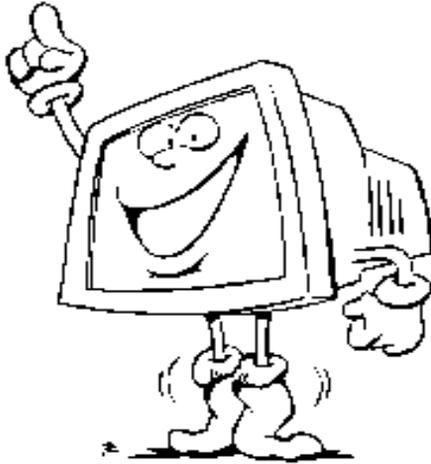


EXPLANATION OF BENEFITS											
LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION										<b>DENTI-CAL</b> <small>CALIFORNIA MEDI-CAL DENTAL PROGRAM                      P.O. BOX 15609, SACRAMENTO, CA 95852-0609</small>	
LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY										No <u>CHECK</u> <b>00596352</b>	
PROVIDER No <u>1234567899</u>										<b>DATE: 08/15/12 PAGE NO. 1</b> of 3	
<b>Adams, James, DDS</b> <b>30 Center Street</b> <b>Anytown, CA 95814</b>										STATUS CODE DEFINITION P = PAID D = DENIED A= ADJUSTED	
PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT											
BENEFICIARY NAME			MEDICAL 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				99999999D	99999999D		F	mm/dd/yy	
C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C	12168101357	15	D7210	06/10/12	A 266B	- 95.00	- .00			- .00	
C		14	D2140	06/10/12	A	- 50.00	- 39.00			- 39.00	
C		13	D2140	06/10/12	A	- 50.00	- 39.00			- 39.00	
CLAIM TOTAL						-195.00	- 78.00			- 78.00	
B	LAST	FIRST				99999999D	99999999D		F	mm/dd/yy	
C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C	12168101357	15	D7210	06/10/12	P	95.00	85.00			85.00	
C		14	D2140	06/10/12	P	50.00	39.00			39.00	
C		13	D2140	06/10/12	P	50.00	39.00			39.00	
CLAIM TOTAL						195.00	163.00			163.00	
*TOTAL ADJUSTED CLAIMS						.00	85.00			85.00	
**PROVIDER CLAIMS TOTAL						132.00	186.00			186.00	
CLAIMS SPECIFIC						NON CLAIMS SPECIFIC					
AMOUNT PAID		ADJUSTMENT AMOUNT		PAYABLES AMOUNT		LEVY AMOUNT		A/R AMOUNT		CHECK AMOUNT	
101.00		85.00								186.00	

# *Important Phone Numbers & Websites for DENTI-CAL Providers*



PROVIDER TOLL-FREE LINE	1-800-423-0507
BENEFICIARY TOLL-FREE LINE	1-800-322-6384
A.E.V.S. (to verify beneficiary eligibility)	1-800-456-2387
A.E.V.S. HELP DESK (Medi-Cal)	1-800-541-5555
P.O.S. / INTERNET HELP DESK	1-800-541-5555
MEDI-CAL WEBSITE (to verify beneficiary eligibility)	<a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a>
DENTI-CAL WEBSITE	<a href="http://www.denti-cal.ca.gov">www.denti-cal.ca.gov</a>
EDI TECHNICAL SUPPORT	1-916-853-7373
DENTI-CAL FORMS (FAX #)	1-877-401-7534
CA DEPT OF PUBLIC HEALTH <a href="http://hfcis.cdph.ca.gov/servicesandfacilities.aspx">http://hfcis.cdph.ca.gov/servicesandfacilities.aspx</a>	



# *Electronic Data Interchange (EDI)*

*Make your computer  
work for you!*

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- **How EDI Works**

Computer/Modem → Phone Line → Denti-Cal/Other  
Payers → Reports come back to you

- **EDI Features**

Receive NOAs & RTDs electronically  
Special labels & red-bordered envelopes  
Special P.O. Box for attachments  
Reports help track claims

- **EDI Enrollment/Information**

Provider Support Services:

Enrollment Packets  
How-To Guides  
EDI Seminar Reservations  
General Information

EDI Support:

Technical Information & Assistance





# 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 - Workshop

Registration #: 06-2210- Units Earned: 6

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.”



# WORKSHOP SEMINAR

## Evaluation Form

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

1. Do you have Internet access to utilize the Denti-Cal website?     Yes     No
2. How valuable was the information on the location and content of the Denti-Cal website?  
 Very Valuable     Above Average     Average     Below Average
3. How valuable was the overview of the Enrollment process?  
 Very Valuable     Above Average     Average     Below Average
4. How valuable was the overview of the Eligibility process?  
 Very Valuable     Above Average     Average     Below Average
5. How valuable was the information presented on the Forms process?  
 Very Valuable     Above Average     Average     Below Average
6. How valuable was the information presented on the Appeals process?  
 Very Valuable     Above Average     Average     Below Average
7. How effective was the trainer in presenting this seminar?  
 Very Effective     Above Average     Average     Below Average
8. What was your overall evaluation of the seminar in acquainting you with the Denti-Cal program?  
 Very Valuable     Above Average     Average     Below Average
9. How valuable was the review of the Manual of Criteria?  
 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: \_\_\_\_\_