

# Denti-Cal California Medi-Cal Dental Bulletin

April 2011  
Volume 27, Number 4

## This Issue:

**p1** Processing Protocol for all Surgical Extraction Procedures

**p2** New Adjudication Reason Codes to Deny Dental Treatment that is not Medically Necessary Precedent to a Medical Treatment  
Helpful Hint

**p3** Health Insurance Portability and Accountability Act (HIPAA) Compliant Transaction Standards to Change Effective January 2012

**p4** Verify Your Tax Identification Number (TIN)

### Training Seminars:

Go to our website to Reserve Your Spot.

**Simi Valley**  
Basic & EDI/D318 - Apr 6, 2011

**Long Beach**  
Workshop/D319 - Apr 7, 2011

**Ortho/D320** - Apr 8, 2011

**Fresno**  
Basic & EDI/D321 - Apr 14, 2011

**Fremont**  
Basic & EDI/D322 - Apr 15, 2011

**Fullerton**  
Workshop/D323 - Apr 20, 2011

**Ontario**  
Basic & EDI/D324 - Apr 21, 2011  
Advanced/D324 - Apr 22, 2011

## Processing Protocol for all Surgical Extraction Procedures

**Procedure D7210 – surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.**

Claims and Treatment Authorization Requests (TARs) for Procedure D7210 **will not be payable based solely on documentation** when the radiograph does not justify the degree of difficulty. When the radiograph clearly depicts a simple extraction (Procedure D7140) but the documentation states, for example, that the tooth fractured during the procedure and/or a flap had to be elevated and/or the tooth had to be sectioned, Procedure D7210 will be modified to Procedure D7140 with adjudication reason code (ARC) 050.

ARC 050 has been modified to read: “Surgical extraction procedure has been modified to conform to radiographic appearance.”

Providers may submit supporting photographs (in addition to preoperative radiographs) as evidence to support their claim that a surgical approach was used. Should the additional evidence support the claim for a surgical extraction (Procedure D7210), it can be allowed as requested. The **minimum number** of photographs necessary to depict the surgical extraction will be considered for payment.

The above criteria also apply when an extraction is requested for a deciduous tooth near exfoliation. The extraction will be denied when the radiograph is reviewed and there is no medically necessary documentation to justify the extraction. ARC 049 will be used to deny these requests.

ARC 049 reads: “Extractions are not payable for deciduous teeth near exfoliation.”

*continued pg 2*

**Procedure D7250 – surgical removal of residual roots (cutting procedure)**

Providers are reminded that Procedure D7250 is for residual root(s) completely covered by bone. When a radiograph demonstrates that the root(s) are not completely covered by bone, Procedure D7250 will be modified to a surgical extraction (Procedure D7210) or to a simple extraction (Procedure D7140) per the radiographic appearance.

**Procedures D7220, D7230, D7240 and D7241 –removal of impacted teeth**

Extraction of impacted teeth must be justified on a **tooth by tooth basis**. Extractions must be medically necessary to be payable. Potential problems or anticipated problems with the angulation or positioning of the impacted tooth will no longer be considered. Refer to Volume 27, Number 1, January 2011...

ARC 048 has been modified to read: “Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.”

ARC 648 has been modified to read: “Per clinical screening, extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.”

ARC 650 has been modified to read: “Per clinical screening, surgical extraction procedure has been modified to conform to radiographic appearance.

---

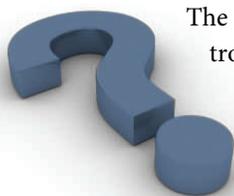
## **New Adjudication Reason Codes to Deny Dental Treatment that is not Medically Necessary Precedent to a Medical Treatment**

The following new Adjudication Reason Codes (ARC) will be used to deny Treatment Authorization Requests (TARs) when the requested dental procedures are not Federally Required Adult Dental Services (FRADS) and the supporting documentation does not justify that the dental procedures are medically necessary precedent to a medical treatment.

- ARC 268B The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
- ARC 268C The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate for a FRADS that may be a covered benefit.

---

## **HELPFUL HINT**



The Health Insurance Portability and Accountability Act (HIPAA), a federal law, sets forth national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. Denti-Cal must follow HIPAA standards. Denti-Cal reminds providers to prevent disclosing, and make all efforts to protect, any beneficiary protected health information (PHI) on envelopes, such as radiograph envelopes, sent to the Program. Disclosure is the release, transfer, provision of access to, or divulging in any other manner of protected health information outside the entity holding the information.

## Health Insurance Portability and Accountability Act (HIPAA) Compliant Transaction Standards to Change Effective January 2012

To comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, Denti-Cal is preparing to accept electronic claim data in the updated Version 5010 format. The following information describes components Denti-Cal will implement in January 2012. Changes will continue to be communicated through regular provider bulletins.

### Transaction Standards

Denti-Cal will implement the following standards as noted below and further described in subsequent paragraphs.

Transaction Type	Title	Current Version	New Version
ASC *X12N 837	Health Care Claims (Dental)	004010X097A1	005010X224A2
ACS X12N 835	Health Care Claim Payment/Advice	004010X091A1	005010X221A1
ASC X12N 276/277	Health Care Claim Status Inquiry and	004010X093A1	005010X212

*\*Accredited Standards Committee (ASC X12N)*

### Health Care Claims (837)

Denti-Cal will accept Version 5010A2 of the 837 Standard Transaction for Dental claims beginning in January 2012. Trading partners will be required to submit test transactions and receive certification in the updated 5010A2 format prior to submitting production transactions. The 4010A1 format will continue to be accepted until trading partners have gone through the testing and certification process. It is very important to review your monthly bulletins for more detailed instructions and implementation schedules related to HIPAA compliance.

Note: Treatment Authorization Requests (TARs) will continue to be submitted using the 837 Standard Transaction; Denti-Cal will not be implementing the 278 Standard Transaction (Services Review Request for Review/Response).

### Remittance Advice (Health Care Claim Payment/Advice) for All Claim Types (835)

Beginning in January 2012, Denti-Cal will generate the updated 5010A1 format of the 835 Standard Transaction for claims remittance advice (Explanation of Benefits) information. At that time, the 4010A1 format of the 835 file will no longer be available to providers who elect to receive an electronic remittance advice with the 835 transaction. Denti-Cal will continue to provide a supplemental file upon request that contains an additional level of detail not provided by the standard transaction. The format of this supplemental file will not be changing.

*continued pg 4*

## Health Care Claim Status Inquiry and Response (276/277)

Denti-Cal will implement version 5010 of the 276/277 Standard Transaction formats (Health Care Claim Status Inquiry and Response) in January 2012.

### Testing

Denti-Cal is not currently prepared to accept or acknowledge test transactions in the 5010 format from its trading partners. Additional information regarding testing instructions and schedules will be provided in future bulletins.

### Technical Specifications (Companion Guides)

Currently, Denti-Cal Draft Companion Guides are being developed and will be made available upon completion.

### Frequently Asked Questions

For additional information regarding HIPAA, please refer to the following websites:

- Medi-Cal website:  
[files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa\\_m.asp](http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_m.asp)
- Department of Health Services Office of HIPAA Compliance:  
[www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/default.aspx](http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/default.aspx)
- Department of Health and Human Services  
[aspe.hhs.gov/admsimp/](http://aspe.hhs.gov/admsimp/)

---

## Verify Your Tax Identification Number (TIN)

The California Medi-Cal Dental Program (Denti-Cal) reports annually to the Internal Revenue Service (IRS) the amount paid to each enrolled billing provider. The business name and TIN must match exactly with the name and TIN on file with the IRS. If the business name and TIN do not match, the IRS requires Denti-Cal to withhold 28% of future payments.

### Tax Identification Number

The TIN may either be a Social Security Number (SSN) or an Employer Identification Number (EIN). Denti-Cal uses the TIN to report earnings to the IRS, which are printed on the front of the check and on the Explanation of Benefits (EOB) you receive from Denti-Cal. Please verify that the business name and TIN on the next check/EOB you receive from Denti-Cal are correct. If the business name and TIN appearing on your Denti-Cal check/EOB are correct, you do not need to notify Denti-Cal.

### Updating Your Tax Identification Number

Updating your TIN is necessary only when:

- If your legal name and/or TIN are incorrect, a [Medi-Cal Supplemental Changes - DHS 6209 \(Rev. 2/08\)](#) form may be used to make changes if the entity itself has not changed. Please attach a valid, legible copy of a legal document for the name change and/or an official document from the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109C).

*continued pg 5*

- If your business type has changed (for example: sole proprietorship, corporation or partnership) you will be required to complete a new [Medi-Cal Provider Group Application - DHS 6203 \(Rev. 2/08\)](#) or a [Medi-Cal Provider Application - DHS 6204 \(Rev. 2/08\)](#), [Medi-Cal Disclosure Statement - DHS 6207 \(Rev. 2/08\)](#), and [Medi-Cal Provider Agreement - DHS 6208 \(Rev 2/08\)](#).
- If you have incorporated, attach a valid, legible copy of the Articles of Incorporation showing the name of your corporation and a legible copy of an official document from the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109-C).
- If your corporation is doing business under a fictitious name, attach a valid, legible copy of the fictitious name permit issued by the Dental Board of California.

To obtain current forms, please contact the Denti-Cal Telephone Service Center at (800) 423-0507 or visit the Denti-Cal website: [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov). Failure to submit the appropriate forms and supporting documents will delay the processing of your application and will be returned as incomplete.

For additional information or questions regarding the verification of TINs, please call the Denti-Cal Telephone Service Center at (800) 423-0507.



PO Box 15609  
Sacramento, CA  
95852-0509  
(800) 423-0507