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Healthy Families Program Transition: Continuing Dental Treatment of Your Healthy Families Program Beneficiaries

In order to ensure continuity of care for Healthy Families Program (HFP) beneficiaries that are transitioning to the Medi-Cal Program, Denti-Cal will honor approved prior authorizations issued by the HFP dental plans where the services provided and billed are covered by the Denti-Cal Program.

Background

Pursuant to Assembly Bill (AB) 1494, (Committee on Budget, Chapter 28, statutes of 2012) (Amended by AB 1468, Chapter 438, most of the HFP enrollees will transition to Medi-Cal as targeted low-income Medicaid children, as allowed under federal law, to begin no sooner than January 1, 2013. The transition will occur in four phases; a HFP enrollee's dental services will transition at the same time as their medical coverage. All children, with the exception of children residing in Sacramento and Los Angeles Counties, will be provided dental services under the Medi-Cal Dental Fee-for-Service (FFS) Program. Children residing in Sacramento County will be provided dental services through a Dental Managed Care plan. Children residing in Los Angeles County will be provided dental services through either a Dental Managed Care plan or the Medi-Cal Dental FFS Program.

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Current Prior Authorization Process

The Denti-Cal Program requires prior authorization for certain services prior to treatment being performed by providers. A list of procedures that require prior authorization can be found in the Medi-Cal Dental Program Provider Handbook under the Manual of Criteria (MOC). When a provider submits a claim for payment for services performed, Denti-Cal reviews the claim to ensure required prior authorization was obtained. Services that did not receive the required prior authorization or are not a benefit of the Denti-Cal Program are denied for payment.

Whenever possible, providers are encouraged to complete all authorized treatment prior to the transition since not all HFP dental benefits are covered Denti-Cal benefits nor are reimbursable at the same rate .

Applying HFP Prior Authorizations to Medi-Cal Services

When providers submit claims to Denti-Cal for a service that has an approved prior authorization from a HFP dental plan, providers must do the following to ensure their claim is adjudicated correctly:

- Confirm the beneficiary that transitioned from the HFP is eligible for Medi-Cal prior to performing the service.
- Confirm that the planned service is a covered benefit within Denti-Cal. (You can confirm the service is an approved Medi-Cal service by clicking here: MOC.)
- If the prior authorization issued by the HFP is not for a covered Denti-Cal service, confirm there is a comparable covered Denti-Cal procedure. (See HFP Prior Authorization to Denti-Cal Benefit Crosswalk table below).
- Provide services within the HFP dental plan's approved authorization period.
- Services must be performed by **an enrolled Denti-Cal provider**.
- When submitting claims for payment, submit a copy of the approved prior authorization.

  Note: For providers submitting claims with approved prior authorizations from a HFP dental plan through Electronic Data Interchange (EDI), providers must indicate that an attachment is being provided or include a digitalized image reference number assigned to a scanned copy of the HFP prior authorization. .
- Claims for payment will be made as stipulated in the Denti-Cal Schedule of Maximum Allowances (SMA) in the Provider Handbook.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OPERATING RULES – PHASE II

Electronic Data Interchange (EDI) Transactions

Currently, EDI transactions can be accepted from certified business partners for the current business day until 3:45 p.m. PST. Effective January 1, 2013, Denti-Cal will accept these transactions until 6:00 p.m. PST

For more information, please contact Provider Services toll-free at (800) 423-0507, or (916) 853-7373 and ask for EDI Support. Requests may also be sent by e-mail to denti-caledi@delta.org.

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If a provider has an approved prior authorization from a HFP dental plan for a service that is not a covered Denti-Cal procedure or crosswalked in the list below, Denti-Cal will not accept the approved prior authorization and the procedure will be denied. For example:

- If an approved prior authorization is for CDT 11-12 Code D2542 (Onlay – metallic – two surfaces), Denti-Cal will not honor the prior authorization, since onlays are not a covered Denti-Cal service. In this case, a provider will need to:
  - Complete the services listed on the prior authorization before the beneficiary transitions to Medi-Cal, or
  - Submit a new request for prior authorization to Denti-Cal for an approved benefit after the beneficiary transitions to Medi-Cal.

If a provider receives a denial for payment for a covered Denti-Cal procedure, a Claim Inquiry Form (CIF) can be submitted plus any additional documentation and radiographs pertinent to the procedure for reconsideration.

If a provider is in the middle of a treatment plan for a beneficiary for a service with an approved prior authorization from a HFP dental plan but that is a non-Medi-Cal service, and the service will not be completed by the time the beneficiary transitions to Denti-Cal, the provider should call the Denti-Cal Provider Customer Service line at 1-800-423-0507 for further information.

*HFP Prior Authorization to Denti-Cal Benefit Crosswalk**

If you have an approved prior authorization from a HFP dental plan for:		To receive payment for claim, you must complete and bill this procedure:	
CDT 11-12 Code	**CDT 11-12 Code Description**	**CDT 11-12 Code**	**CDT 11-12 Code Description**
D2720	Crown - resin with high noble metal	**D2721**	Crown - resin with predominantly base metal
D2722	Crown - resin with noble metal	**D2721**	Crown - resin with predominantly base metal
D2750	Crown - porcelain fused to high noble metal	**D2751**	Crown - porcelain fused to predominantly base metal
D2752	Crown - porcelain fused to noble metal	**D2751**	Crown - porcelain fused to predominantly base metal
D2780	Crown - 3/4 cast high noble metal	**D2781**	Crown - 3/4 cast predominantly base metal
D2782	Crown - 3/4 cast noble metal	**D2781**	Crown - 3/4 cast predominantly base metal
D2790	Crown - full cast high noble metal	**D2791**	Crown - full cast predominantly base metal
D2792	Crown - full cast noble metal	**D2791**	Crown - full cast predominantly base metal
D2794	Crown - titanium	**D2791**	Crown - full cast predominantly base metal
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	**D2933**	Prefabricated stainless steel crown with resin window
D3353	Apexification/Recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	**D3310**	Endodontic therapy, anterior tooth (excluding final restoration)
		D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)
		D3330	Endodontic therapy, molar tooth (excluding final restoration)

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*If a provider has an approved prior authorization from a HFP dental plan that is not for a procedure code identified in the left column in the table above, the provider should contact the Denti-Cal Provider Customer Service line at 1-800-423-0507.

What to Do If You Are Not Enrolled In Denti-Cal:

- If you would like to continue treating your Healthy Families patients once they transition, you must enroll, depending on the county.
- Your enrollment application will be expedited.
- Click here for the Enrollment Application Guide which includes direct links to the applicable enrollment forms or call the Provider Customer Service line at 1-800-423-0507 for an enrollment application.
- When submitting your application, make sure to write HEALTHY FAMILIES on the top of the enrollment form DHCS 6203 or DHCS 6204 in the box labeled "For State Use Only" to ensure it is expedited.
- Feel free to call our Provider Customer Service line at 1-800-423-0507 if you have any questions about the enrollment process.

What to Do If You Are a Current Denti-Cal Provider:

- To receive additional Denti-Cal patient referrals, ensure you are on the Patient Referral List. You may sign up by clicking here. Print, fill out the form, and send it to the address indicated on the top of the form.
- Once these beneficiaries transition into the Medi-Cal program ,you will need to bill Denti-Cal for dental services provided.
- If you currently serve Healthy Families Program patients, please continue to verify eligibility through your normal processes. If the patient is no longer eligible for Healthy Families, verify their Medi-Cal eligibility.
- To check Medi-Cal eligibility, please call 1-800-456-2387.

New Aid Codes: 5C, 5D, H1, H2, H3, H4, and H5

Recent proposed legislation (Budget Trailer Bill of 2012) expanded the Medi-Cal program by increasing the Federal Poverty Level (FPL) limits to allow eligibility for more children. Elimination of the Healthy Families Program (HFP) requires Presumptive Eligibility (PE) aid codes to continue the eligibility of children currently in the HFP until they reach their redetermination date. When the children reach their redetermination date, they may move into the new expanded Medi-Cal Targeted Low Income FPL for Children Program as determined by county.

Presumptive Eligibility for the HFP Transitional Children (Aid Codes 5C and 5D)

The Budget Trailer Bill of 2012 eliminates the HFP and transitions existing HFP children to the Medi-Cal program. This transitioned group requires two new PE aid codes:

1. **Aid Code 5C**: Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children. Provides no-cost, full scope, Medi-Cal coverage with no premium payments, to children with family income at or below 150% of the federal poverty level during the transition period done by the State until the annual eligibility review.

2. **Aid Code 5D**: Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children. Provides full scope Medi-Cal coverage with a premium payment, to children with family income above 150% and up to 250% of the federal poverty level during the transition period.

The HFP children's group includes Aim-linked infants at and below 250% of the FPL.

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Aid Code	Benefits	SOC	Program/Description
5C	Full Scope	N	HFP to Medi-Cal Transitional PE-No Premium
5D	Full Scope	N	HFP to Medi-Cal Transitional PE-Premium Payment

Medi-Cal Targeted Low Income FPL for Children (Aid Codes H1, H2, H3, H4, and H5)

The 2012 Budget Trailer Bill proposes to add Section 14005.27 to the Welfare and Institutions Code to expand the Medi-Cal program to include targeted low-income children with family incomes up to and including 200% of the FPL pursuant to 1905(u)(2)(8) of the Social Security Act. Additionally, state law adopts the option to use less restrictive income and resources methodologies to exempt all resources and disregard income at or above 200% up to 250% FPL pursuant to 1902(r)(2) of the Social Security Act.

To support this change, the following aid codes were created:

1. **Aid Code H1**: Title XXI, Medi-Cal Targeted Low Income FPL for infants. Provides full scope, no-cost Medi-Cal for infants who are U.S. citizens, have satisfactory immigration status, or unverified citizenship*. Coverage is up to the month of their first birthday or continues beyond one year when in an inpatient status that began before the first birthday. Family income is above 200% up to 250% of the FPL.

2. **Aid Code H2**: Title XXI, Medi-Cal targeted low income FPL for children. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages one through the month of the 6th birthday or continues when in an inpatient status which began before the 6th birthday for family income at or below 133 up to 150 percent of federal poverty level.

3. **Aid Code H3**: Title XXI, Medi-Cal Targeted Low Income FPL for Children. Provides full scope, subject to premium payment. Provides full-scope coverage based on a premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship from age 1 to the month of their 6th birthday or continues when in an inpatient status which began before the 6th birthday, with family income above 150 percent up to 250 percent of the FPL.

4. **Aid Code H4**: Title XXI, Medi-Cal targeted low income FPL for children. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages six through the month of the 19th birthday or continues when in an inpatient status which began before the 19th birthday for family income above 100 percent up to 150 percent of the FPL.

5. **Aid Code H5**: Title XXI, Medi-Cal Targeted Low Income FPL for Children - full scope, subject to premium payment. Provides full-scope coverage based on a premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship from age 6 to the month of their 19th birthday or continues when in an inpatient status which began before the 19th birthday, with family income above 150 percent up to 250 percent of the FPL.

   *Refer to All County Welfare Directors Letter 09-65, December 31, 2009, SSN Data Match for Verification of Citizenship and Identity for Purposes of Medi-Cal Eligibility.

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Aid Code	Benefits	SOC	Program/Description
H1	Full Scope	N	Medi-Cal Targeted Low Income FPL for Infants
H2	Full Scope	N	Medi-Cal Targeted Low Income FPL Child 1-6 133-150%
H3	Full Scope	N	Medi-Cal Targeted Low Income FPL Child 1-6 150-250% Prem
H4	Full Scope	N	MC Targeted Low Income FPL Child 6-19 100-150%
H5	Full Scope	N	MC Targeted Low Income FPL Child 6-19 150-250% Prem

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