

Denti-Cal California Medi-Cal Dental Bulletin

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Training Seminars:

Want to learn more about the Denti-Cal program? Come to one of our training seminars. Go to our website to Reserve Your Spot.

San Diego
Basic & EDI/D376 - June 14, 2012

San Diego
Advanced/D377 - June 15, 2012

Woodland Hills
Basic & EDI/D378 - June 27, 2012

Fullerton
Basic & EDI/D379 - June 28, 2012

Fullerton
Advanced/D380 - June 29, 2012

New Adjudication Reason Code 062

Beginning June 1, 2012 Deep Sedation/General Anesthesia (D9220/D9221) will be payable only when an induction agent is used and indicated in the anesthesia report. When an induction agent is not used, procedure D9220/D9221 will be modified to Intravenous Conscious Sedation/Analgesia (D9241/D9242). The modification will be indicated with the new Adjudication Reason Code (ARC) 062. ARC 062 reads as follows:

062 General anesthesia is not a benefit when the anesthesia record does not indicate an anesthetic induction agent was administered. Intravenous conscious sedation is the maximum benefit.

More information about ARCs can be found in "[Section 7 - Codes](#)" in the Provider Handbook or -by calling the Denti-Cal Telephone Service Center at (800) 423-0507.

Clarification: Benefits for Pregnant and Postpartum Women (*Revised*)

This bulletin clarifies Denti-Cal Bulletin [Volume 26, Number 11](#) (May 2010).

Denti-Cal would like to clarify to providers that all pregnant beneficiaries in any full or limited scope aid codes, **including adults 21 years of age and older**, are eligible for certain pregnancy-related and emergency services.

Aid Codes Eligible for Pregnancy-Related Benefits

All pregnant and postpartum women in any full or limited scope aid code, including those age 21 and older, are eligible for the pregnancy-related dental benefits listed below, provided that all requirements in the Manual of Criteria (MOC) for that procedure are met.

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Pregnancy-Related Benefits

CDT 11-12 Code	CDT 11-12 Code Description
D0120	Periodic oral evaluation – established patient <i>(for beneficiaries under age 21 only)</i>
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 <i>(for beneficiaries age 21 and over)</i>
D1120	Prophylaxis - child <i>(for beneficiaries under age 21 only)</i>
D1203	Topical application of fluoride – child <i>(for beneficiaries under age 21 only)</i>
D1204	Topical application of fluoride – adult <i>(for beneficiaries age 21 and over)</i>
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth, or tooth bounded spaces per quadrant
D4260	Osseous surgery (including flap entry and closure) –four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) –one to three contiguous teeth or tooth bounded spaces, per quadrant
D4341	Periodontal scaling and root planing – four or more teeth 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

Claims must be submitted for all of the above procedures. Do not submit TARs for any pregnancy-related services.

A current periodontal chart is required for all surgical periodontal procedures along with photographs, for procedures D4210 and D4211. In addition, all criteria stated in the Manual of Criteria (MOC) will apply with the following exceptions:

- ◆ **D4260** and **D4261** Osseous Surgery - arch radiographs are **not** required but periapical radiographs of the involved areas **are** required.
- ◆ **D4341** and **D4342** Periodontal Scaling and Root Planing - arch radiographs are **not** required but periapical radiographs of the involved areas **are** required.

If you receive a denial for a covered service for a pregnant/postpartum beneficiary, you should submit a Claim Inquiry Form (CIF) indicating “PREGNANT” or “POSTPARTUM” in the “REMARKS” field plus any additional documentation and radiographs pertinent to the procedure for reconsideration.

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Omnibus Budget Reconciliation Act (OBRA) Emergency Dental Services Only

Pregnant and postpartum beneficiaries in any limited scope aid code are also eligible to receive the emergency dental services listed below. Claims submitted for emergency services require a clinical emergency certification statement and, when applicable, radiographs and/or other documentation to justify the procedure must also be submitted. Providers must follow the emergency certification instructions below to document the emergency. **Simply stating “Pregnant” or “Postpartum” for emergency procedures without further documentation of the emergency is insufficient and the claim will be denied.**

OBRA Emergency Dental Services

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)

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OBRA Emergency Dental Services (Continued)

CDT 11-12 Code	CDT 11-12 Code Description
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
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
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	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)
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

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OBRA Emergency Dental Services (Continued)

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

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OBRA Emergency Dental Services (Continued)

CDT 11-12 Code	CDT 11-12 Code Description
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report

All pregnant/postpartum women in any limited scope aid code are eligible for **both** the pregnancy-related benefits described above and the **emergency benefits above**. The listed emergency benefits are also available to women (pregnant or not) and to men and children whose Medi-Cal coverage is limited to “emergency services only.”

Note: Pregnant/postpartum women in full scope aid codes are eligible for benefits described in the Pregnancy-Related Benefits table above and Federally Required Adult Dental Services (FRADS) [[Denti-Cal Bulletin, May 2012, Volume 28, Number 7](#)].

When the procedures listed above are provided for beneficiaries in any limited scope aid code (regardless of whether they are pregnant or postpartum), an emergency certification statement is always required. This statement must either be entered in the “Comments” area (Box 34) on the claim form or attached to the claim. It must:

- ◆ Describe the nature of the emergency, including clinical information pertinent to the beneficiary’s condition; and
- ◆ Explain why the emergency services provided were considered immediately necessary.

The statement must be signed by the dentist providing the services (in the “Comments” area or on the attached statement) and must provide enough information to show the existence of an emergency dental condition and need for immediate treatment. Merely stating that an emergency existed or that the patient was in pain is insufficient. When applicable, necessary documentation and/or radiographs to justify the procedure must be submitted with the claim.

The list of pregnancy-related, emergency and FRADS is intended to encompass the vast majority of treatment procedures that may be required to alleviate or prevent conditions that may potentially complicate a pregnancy. It must be understood that when multiple treatment options exist, the Program has included as a benefit the lowest cost procedure that will ameliorate the problem.

Should a provider submit and receive a denial for a Denti-Cal procedure not on the list of pregnancy-related, emergency or FRADS, a Claim Inquiry Form (CIF) may be submitted with medical and/or radiographic documentation that supports the fact that the treatment that they provided was indeed critical and immediately necessary to alleviate or prevent a condition that would complicate a pregnancy. The documentation should also support the fact that other treatment options included on the list are insufficient or contraindicated. Requests for payment will be considered on a case by case basis.

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REMINDER

Definitions of “Managing Employee” and “Ownership Interest”

Providers are reminded of the California Code of Regulations, Title 22 definitions of “Managing employee” and “Ownership interest:”

Section 51000.12. Managing Employee.

“Managing employee” means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an applicant or provider.

Section 51000.13. Ownership Interest.

“Ownership interest” means the possession of equity in the capital, the stock, or the profits of the applicant or provider.

Helpful Hints to Avoid Denials

Denti-Cal would like to offer the following to help offices avoid delays in payment and the denial of Claims and Treatment Authorization Requests (TARs).

- ◆ Beneficiaries who turn 21 years of age;
 - Authorized procedures on a Notice of Authorization (NOA):
 - Denti-Cal authorized treatment on an NOA may be allowed even though the beneficiary's 21st birthday occurs before the expiration date on the NOA. Procedures requiring prior authorization will be payable as long as the beneficiary is eligible at the time services are rendered.
 - Orthodontic coverage is a benefit to age 21 for qualifying beneficiaries. Authorized Ortho treatment may be rendered on an eligible beneficiary through the month of their 21st birthday.
- ◆ All Denti-Cal forms: i.e. claims/TARs/NOAs/RTDs/CIFs require a live signature from the provider or authorized staff member. Rubber stamps or “signature on file” cannot be accepted.
- ◆ Use the existing NOA for a re-evaluation of a denied procedure by marking the re-evaluation box on the upper right corner and submit all required documentation and/or radiographs. Do not submit a Claim Inquiry Form (CIF) for this purpose.
- ◆ Arch radiographs are defined as a combination of radiographs that best depicts the condition of the remaining teeth in the arch. Arch films are considered current for a period of 36 months.
- ◆ Arch radiographs are not required for patients under the age of 21.
- ◆ Do not use x-ray envelopes for periodontal charts or any other type of documentation. X-ray envelopes are to be used for radiographs and photographs only. Staple all attachments to the back of the Claim/TAR form.
- ◆ Do not reuse X-ray envelopes that have been returned to you by Denti-Cal.

Common Adjudication Reason Code (ARC) Denials

The most common adjudication reason code denials are as follows:

- ◆ Not submitting documentation or submitting incomplete documentation for an emergency procedure. (ARC 267, 267i)
- ◆ Submitted third molar extractions do not meet the program guidelines (ARC 048)
- ◆ Mislabeled radiographs and photographs:
 - Radiographs/photographs are not dated (ARC 029a)
 - Radiographs are dated after the date of service for the procedure (ARC 029e)
 - Radiographs/photographs have multiple dates (ARC 029c)
 - Date on the photographs do not match the date of service indicated on the claim for the photographs (ARC 031)
 - Radiographs/photographs are not labeled right/left or teeth numbers are not indicated (ARC 266g)

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HIGHLIGHT

For Faster Denti-Cal Payments, Enroll in Direct Deposit Today!

Denti-Cal encourages providers to enroll in the direct deposit program. With direct deposit, Denti-Cal automatically deposits payments into a provider's designated savings or checking account, which means:

- No more lost or misdirected checks
- No more waiting for checks to arrive in the mail
- No more trips to the bank
- Payments are available faster

To participate in the program, providers must complete and sign the attached Direct Deposit Enrollment Form. Providers can also obtain a form by calling the Telephone Service Center at (800) 423-0507, or by writing to Denti-Cal at this address:

Denti-Cal
Attn: Provider Enrollment Department
PO Box 15609
Sacramento, CA 95852-0609

The back of the form contains instructions for completing the Direct Deposit Enrollment Form. The Direct Deposit Enrollment Form must include the following:

- The provider's original signature (in blue ink)
- A preprinted, voided check attached to the form

Providers must mail the completed form to Denti-Cal at the address shown above.

Upon receipt of the Direct Deposit Enrollment Form, Denti-Cal sends a "test" deposit to the bank. This will result in a "zero" deposit for that payment date. The test cycle usually takes three to four weeks to complete. During the test cycle period, providers will continue to receive Denti-Cal payment checks through the mail.

The amount of each deposit will appear on the corresponding Explanation of Benefits once direct deposit begins.

More information about direct deposit can be found in "Section 3 - Enrollment Requirements" of the provider Handbook.

For questions, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.

- ◆ Submitting non-diagnostic radiographs (ARCs 266c, 266i, 266k)
- ◆ Providers are not responding to the RTD (ARC 326)
- ◆ Submitting incorrect tooth numbers, surfaces or procedure codes.
- ◆ Photographs not submitted with the claim or Treatment Authorization Request (TAR) for the procedure that it supports (ARC 031/031a)
- ◆ Rendering/NPI # is incorrect or not submitted
- ◆ Not submitting a complete Emergency Certification Statement for a limited scope aid code(ARC 369, 369a)
- ◆ Not submitting documentation or submitting incomplete documentation for an emergency procedure. (ARC 267, 267i)

For a complete listing of adjudication reason codes and their definitions, see "[Section 7 – Codes](#)" in the Provider Handbook.

Medi-Cal Dental Patient Referral Service

Medi-Cal Dental Program (Denti-Cal) providers can take advantage of a free referral service for accepting Denti-Cal patients. This referral service can be an excellent resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service for the state's medically needy.

If you are a provider interested in this service, or need to update the information currently on file, please fill out the attached Medi-Cal Dental Patient Referral Service Form and mail it to:

California Medi-Cal Dental Program
Attn: Enrollment Department
PO Box 15609
Sacramento, CA 95852-0609

The updated Medi-Cal Dental Patient Referral Service Form has been included with the bulletin as an attachment. To access this and other attachments, click on the paperclip icon on the lower-left portion of the Adobe Reader reading pane.



PO Box 15609
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95852-0609
(800) 423-0607