

Denti-Cal FAQs



Elimination of Most Adult Dental Services Provider Frequently Asked Questions (FAQs)

1. Effective July 1, 2009 what optional adult dental services were eliminated?

On July 1, 2009, all optional adult dental services were eliminated. Optional services are services that are not mandated by the federal government to be provided to beneficiaries.

Optional services that were eliminated include:

- *Comprehensive oral evaluations for new or established patients.*
- *Prophylaxis and fluoride treatments.*
- *Amalgam and resin based composite restorations.*
- *Prefabricated and laboratory processed crowns.*
- *Endodontic treatment.*
- *Periodontal procedures including scaling and root planing.*
- *Removable prosthodontic treatment including complete and partial dentures, relines and tissue conditioning and adjustment and repairs.*
- *Fixed prosthodontic procedures.*
- *Implant procedures.*

2. Which beneficiaries or services were not affected?

The following beneficiaries or services administered by the Department of Health Care Services for adults were not affected by this policy on or after July 1, 2009:

- *Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or dentist in this state. Federal law requires the provision of these services. The services that are allowable as Federally Required Adult Dental Services (FRADS) can be found in Table 1 in the Denti-Cal Bulletin Volume 25, Number 22, May 2009.*
- *Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. This includes 60 days of post partum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed in either Table 1 (FRADS) or Table 2 (Allowable Procedure Codes for Pregnant Women) as found in the Denti-Cal Bulletin Volume 25, Number 22, May 2009.*
- *Beneficiaries under the age of 21.*

- *Beneficiaries residing in an intermediate care facility (ICF) or a skilled nursing facility (SNF), as defined in the Health and Safety Code (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k). Dental services do not have to be provided in the facility to be payable. See [Denti-Cal Bulletin Volume 25, Number 22, May 2009](#) for further details.*
- *Dental services precedent to a covered medical service. Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under the FRADS procedures. A precedent dental service that is not on the FRADS list will be evaluated and adjudicated on a case by case basis.*

An adult dental service may be reimbursable if any one of the above exceptions is met. The Manual of Criteria (MOC) will remain in effect and unless otherwise stated all policies remain the same for payable dental services.

3. What about beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after they turn 21 years of age?

Treatment may be completed under the following conditions:

- *If the service requires a Treatment Authorization Request (TAR), all of the following must be met:*
 - *TARs must be received by Denti-Cal for consideration prior to the beneficiary turning 21.*
 - *The treatment must require prior authorization.*
 - *The treatment must be authorized on a Notice of Authorization (NOA).*
 - *The treatment must be completed within the approved authorization period on the NOA.*
- *For treatment that does not require prior authorization, the treatment must be completed prior to the beneficiary turning 21.*

4. How did the elimination of optional adult dental services affect beneficiaries treated in a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal Health Center (THC)?

Services provided in an FQHC, RHC or TCH are subject to the same elimination of optional adult benefits (with exclusions) as noted above.

5. Were emergency services affected?

Emergency procedures are included in the FRADS table of allowable procedures. The criteria in the Manual of Criteria (MOC) still apply.

6. Can a provider be reimbursed for a dental procedure that is not on the FRADS list?

Not under the Denti-Cal program, unless the beneficiary is covered under one of the specified exceptions. Payment arrangements for services not covered under the Denti-Cal program should be explained to the beneficiary and are between the dentist and the beneficiary.

7. Are dental managed care plans/providers affected?

Yes.

8. Is the \$1,800 annual cap on adult dental services still in effect?

Yes. The cap still applies to allowable dental services.

9. How will fair hearing cases be affected?

If treatment is authorized, the pink authorization form allowing dental services will still be valid through the authorization period on the form.

12. Were Denti-Cal fees affected by this change?

No.