

Quick Reference for Denti-Cal Providers

(This is a summary of key information and requirements of the Denti-Cal program. It is not meant to replace the detailed information in the Denti-Cal Provider Handbook.)

I. PROCESSING A DENTI-CAL PATIENT THROUGH THE DENTAL PRACTICE

Above all: The treating provider must be enrolled as a Denti-Cal provider

- The first criterion for treating Denti-Cal patients is to assure that every dentist in the office providing care to Denti-Cal patients is enrolled as a Denti-Cal provider.
- Enrollment applies to both “billing providers” (i.e. the entity billing Denti-Cal for services) and “rendering providers” (i.e. any associate treating Denti-Cal patients).
- **DO NOT HAVE A NON-ENROLLED DENTIST TREAT DENTI-CAL PATIENTS...EVER!**
- See **Section 3, Enrollment Requirements**, of the “Medi-Cal Dental Program Provider Handbook” (Provider Handbook) and the *Enrollment Tool Kit* under the Provider tab at <http://www.denti-cal.ca.gov> for additional guidance and materials on how to enroll as a Denti-Cal provider.
- In order for an office to have multiple providers, the practice must be enrolled as a group location.

Verifying patient eligibility:

- Make a copy of the patient’s Medi-Cal Benefits Identification Card (BIC). However, please note that Dental Offices may verify eligibility using the Medi-Cal Automated Eligibility Verification System (AEVS), the Point of Service (POS) device, or the Medi-Cal website (www.medi-cal.ca.gov), and may, with the beneficiary’s approval, use the beneficiary’s Social Security Number (SSN) to verify eligibility. For more information regarding ways to verify beneficiary identification and eligibility please visit: http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_32_Number_01.pdf and **Section 4, Treating Beneficiaries**, of the Provider Handbook.
- Verify and copy patient’s photo identification. Photo identification is not required for minors who are 17 years old and younger.
- Patient eligibility should be verified one time each month that services are provided. Eligibility may be verified electronically over the Internet (<https://www.medi-cal.ca.gov/Eligibility/Login.asp>), through a POS device, or by calling the AEVS at 1-800-456-2387, or call the POS/Internet Help Desk at 1-800-427-1295.

Important information for providers:

Dental offices may acquire a variety of information about the patient’s history, the status of a claim, and their provider enrollment status, by calling 1-800-423-0507 and following the prompts to access specific information.

Required Patient Information:

- Please ensure that the radiographs taken reflect, “What you saw when you made the diagnosis”.
- Take necessary radiographs when making a diagnosis, so Denti-Cal can see how your radiograph(s) help to substantiate your diagnosis.
- Radiographs are part of the beneficiary’s clinical record and the original images should be retained by the dentist. Radiographs and photographs will not be returned. (See page 2-17 of the Provider Handbook.)
- Intraoral photographs of teeth are needed on all occlusal, buccal, lingual tooth surfaces to document caries not seen on radiographs, or for any other clinical situations you may need to demonstrate.
- Radiographs are required to justify medical necessity when prior-authorizing scaling and root planing, crowns, dentures and root canal therapy.
- All periodontal procedures require submission of radiographs. Keep the periodontal chart for your record, however submittal is not required.
- Maintain a copy of all radiographs, photos, and notes you send to Denti-Cal for your own records.

What is covered:

- Patients up to age 21 enrolled as Medi-Cal beneficiaries are eligible for Denti-Cal.
- All covered Denti-Cal benefits, with diagnostic policies and documentation requirements, are in Section 5, *Manual of Criteria and Schedule of Maximum Allowances*, of the Provider Handbook
- Common procedures - examinations, prophylaxis, amalgam and composite fillings, stainless steel crowns, pulpotomies, space maintainers, dental sealants, and all emergency procedures - are paid without prior authorization.
- Note policies on covered orthodontic procedures on page 5-101, and orthodontic procedures requiring prior authorization on page 2-19 of the Provider Handbook.
- Prior authorization is needed for root canal therapy, cast crowns, and is recommended for extraction of third molars. (See **Section 6**, *Forms*, of the Provider Handbook for requesting prior authorization.)
 - ✓ For further clarification on Denti-Cal’s policy on third molar extraction, see *the Oral & Maxillofacial Surgery General Policies* on page 5-81 of the Provider Handbook.
- Adults over 21 are eligible for:
 - ✓ Certain services identified as “Federally Required Adult Dental Services (FRADS)” (see **Section 4**, *Treating Beneficiaries*, of the Provider Handbook);
 - ✓ Restored Adult Dental Services (see **Section 4**, *Treating Beneficiaries*, of the Provider Handbook)
 - ✓ Dental services necessary as a condition for other covered medical treatment such as organ transplantation and joint replacement;
 - ✓ Pregnant and post-partum women will receive all dental procedures listed in the Manual of Criteria (see page 4-10 of the Provider Handbook), as long as they meet the required criteria, see **Section 5**, *Manual of Criteria and Schedule of Maximum Allowances*, of the Provider Handbook for criteria.
 - ✓ Adult patients in Long Term Care or Skilled Nursing Facilities are eligible for full Denti-Cal benefits (see **Section 1**, Introduction, of the Provider Handbook).
 - ✓ Regional Center consumers (State Department of Developmental Disabilities beneficiaries) are eligible for full dental services through Medi-Cal.
 - For details, contact the Denti-Cal Service Center, 1-800-423-0507.

II. DENTI-CAL BILLING PROCESS

Use of the TAR/Claim form:

- The Treatment Authorization Request (TAR)/Claim form is a single form used to request prior authorization of treatment from Denti-Cal, and to file claims for reimbursement for services.
- Note page 2-19 of the Provider Handbook for a list of procedures requiring prior authorization.
- See page 6-6 of the Provider Handbook for information on the TAR/Claim form.
- See page 6-34 of the Provider Handbook for a checklist of information that should be provided on the claim forms.

Submitted claim form:

Denti-Cal will respond to a submitted claim in one of two ways:

- It will either pay or deny payment for the service and communicate the payment decision to the dentist through the Explanation of Benefits (EOB) form.

...or...

- It will issue a “Resubmission Turnaround Document” (RTD) form requesting additional information necessary to process the claim.

Explanation of Benefits (EOB):

- Provides details of what was paid and what was denied on a submitted claim.
- EOBs are issued as part of a bulk payment each week and lists claims that have been in process over 18 days.
- Denials are assigned an Adjudication Reason Code indicating why a denial was made. These codes are included on the EOB. See **Section 7, codes** of the Provider Handbook for listing of denial codes.
- See page 6-43 of the Provider Handbook for more information on the EOB.

Resubmission Turnaround Document (RTD):

- Itemizes the additional information that Denti-Cal needs to process a submitted claim or request for prior authorization.
- The dentist has 45 days from the date the RTD was issued to provide the requested information to Denti-Cal.
- See page 6-25 of the Provider Handbook for information on the RTD.
- See page 7-27 of the Provider Handbook for RTD codes and messages.

Avoiding authorization and claim denials:

On both TARs and claims:

- Assure that radiographs, if required, are of diagnostic quality and show what you are seeing as needing treatment.
- Assure that photographs are being submitted to support the procedure being claimed.
- Assure that radiographs and photographs are properly labeled per the Diagnostic General Policies of the Provider Handbook on pages 5-5 and 5-6.
- Consider whether radiographs submitted for payment of restorations demonstrate the restoration was medically necessary.
- Attach treatment notes or other written documentation to show medical necessity of procedures claimed.
- Check the claim form to ensure all required information has been entered, and that the form is signed by the individual completing the form. Denti-Cal forms must be signed in blue or black ink.

Common reasons for claim denials:

- Incomplete or non-submission of necessary radiographs, photographs, or written documentation.
- Claims and documentation that fail to show that treatment was medically necessary.
- Radiographs and photographs not properly labeled or of non-diagnostic quality.
- Clerical errors such as failure to enter dates of service, failure to include treating dentist's NPI, or failure to sign claim form.

Using a Notice of Authorization (NOA) form for prior authorized treatment:

- TARs submitted for prior authorization of treatment will generate a NOA form. Completed NOA is required to be submitted to Denti-Cal when treatment is completed.
- See page 6-15 of the Provider Handbook for more information on the NOA.
- Authorization does not guarantee payment. Payment is subject to beneficiary's eligibility at the time service is rendered.

If a claim is denied:

- When a claim or request for prior authorization is denied, check the adjudication reason code for the denial, found beginning on page 7-1 of the Provider Handbook. When an entire document is denied, refer to the TAR/Claim Policy Codes and Messages, found beginning on page 7-29 of the Provider Handbook.
- Denials referenced on an EOB may be rebilled using a Claim Inquiry Form (CIF – see page 6-29 of the Provider Handbook).
- If in response to a CIF, Denti-Cal upholds the original denial, a provider may request a formal "First Level Appeal." (See page 2-11 of the Provider Handbook on both the CIF process and First Level Appeals.)

Denti-Cal provides direct assistance to dentists:

If you need live assistance on anything related to claim documentation, patient eligibility, covered benefits, call the Denti-Cal Provider Help Line at 1-800-423-0507.