

Denti-Cal California Medi-Cal Dental Bulletin

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Training Seminars

Reserve an available spot for one of our open training seminars.

Riverside—CLOSED
Advanced/D502 - Sept. 17, 2014

Rancho Cucamonga—CLOSED
Advanced/D503 - Sept. 18, 2014

Modesto
Advanced/D504 - Sept 25, 2014

Webinar
Basic & EDI/D505 - Sept. 30, 2014

Provider Enrollment Assistance Line

Speak with an Enrollment Specialist.
Go [here](#) for more information!

Wednesday, Sept. 17, 8 am - 4 pm.

American Sign Language (ASL) Translation Services Available for Denti-Cal Beneficiaries

Denti-Cal would like to advise providers that American Sign Language (ASL) translation services are available to Denti-Cal beneficiaries who may need these services. Either the Denti-Cal provider office or the beneficiary may contact Denti-Cal directly to request an ASL translator to be present at the time of the appointment. When requesting the ASL translation services, please have the following information available:

- ◆ Date of dental appointment
- ◆ Start and end time of appointment
- ◆ Appointment Type (for example: “Dental Appointment, Surgical Appointment, Consult, etc.”)
- ◆ Name of person needing ASL services
- ◆ Office Location Address
- ◆ Office Contact Person Name
- ◆ Office Phone Number

ASL translation services are provided in accordance with Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act (ADA); Title 22 California Code of Regulations, Section 51098.5; Welfare and Institutions Code Sections 10725 and 14105; Title 28 Code of Federal Regulations, Section 35.130(a)(b) require provision of auxiliary aids and services (i.e., interpreting services) necessary to ensure effective communication with deaf, hard of hearing, or deaf-blind individuals.

If you have any questions and are a Denti-Cal Provider, please contact the Provider Customer Service Line at 1-800-423-0507. If you are a beneficiary, please contact the Denti-Cal Toll-Free Beneficiary Customer Service Line at 1-800-322-6384.

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Submit a Properly Completed Justification of Need for Prosthesis (DC054) Form with Requests for Prosthetics

Using the DC054 Form

Providers are required to submit a Justification of Need for Prosthesis Form (DC054) when submitting a Treatment Authorization Request (TAR) for all prosthetic appliances (except full immediate dentures). The DC054 provides complete and detailed information necessary for screening and processing prosthetic cases. The form should include specific information describing the condition of the beneficiary's oral condition and the condition of any existing prosthetic appliances.

Failure to submit a DC054 form will cause a delay processing the request. If the information on the DC054 form is incomplete or contradictory, the requested prosthetic appliance(s) will be denied with Adjudication Code 155 (Procedure requires a properly completed prosthetic DC054 form).

If enrolled to submit electronically, providers also have the option to submit the DC054 form as an electronic attachment with a TAR.

How to Complete the DC054 Form

The following is a sample DC054 form with instructions on how to correctly complete the document.

1. **PATIENT NAME:** Enter the beneficiary's name exactly as it appears on the Medi-Cal Beneficiary Identification Card (BIC).
2. **DATE:** Enter the date the beneficiary was evaluated.
3. **APPLIANCE REQUESTED:** Enter the type of prosthetic appliance requested on the TAR.
4. **EXISTING APPLIANCE:** Enter the type of prosthetic appliance that the beneficiary has or had (regardless of the condition of the appliance or whether the appliance has been lost, stolen or discarded). If the beneficiary has never had any type of prosthetic appliance, check the corresponding box.

Indicate whether the beneficiary wears the existing appliance and the age of the appliance that the beneficiary has (or had). If the appliance is no longer present due to a catastrophic loss (fire, earthquake, theft, etc.), attach the Official Public Service Agency Report. If the prosthetic appliance has been lost in a certified facility or hospital, document the date of the incident and the circumstances of the loss. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details of the loss.

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NEED MORE INFORMATION?

Provider Enrollment Workshops



Are you a dental provider who is interested in joining the Denti-Cal program but don't know where to start? Do you have questions about the Denti-Cal enrollment process? Then please drop-in anytime during the hours scheduled below to attend one of our enrollment workshops! Registration is preferred, but not required.

Date/Time:	Location:	County:
Thursday, Sept. 11, 2014 8:00 AM- 4:00 PM Register Now!	Embassy Suites 250 Gateway Blvd San Francisco, CA 94080 650-589-3400	San Francisco County
Wednesday, Sept. 24, 2014 8:00 AM- 4:00 PM Register Now!	Double Tree by Hilton Hotel 120 S Los Angeles St Los Angeles, CA 90012 213-629-1200	Los Angeles County

5. **EVALUATION OF EXISTING PROSTHETIC APPLIANCES AND/OR EXISTING ORAL CONDITIONS:**

Document the condition of the existing denture base, denture teeth, retention, opposing natural dentition (if applicable), centric occlusion, and vertical relation. If the existing appliance is a cast metal framework partial denture, document the condition of the framework.

When checking a box indicating “inadequate,” a brief explanation is required regarding the reason for the inadequacy.

When requesting a prosthetic appliance for only one arch, **the opposing arch must also be addressed.**

The condition of the soft tissue and hard tissue must be evaluated and reported as either adequate or inadequate — even when the beneficiary does not have an existing prosthetic appliance. If soft tissue or hard tissue is checked “inadequate,” indicate the procedure that will be necessary to correct the inadequacy prior to the construction of an appliance, e.g., tissue conditioning, tuberosity reduction, excision of hyperplastic tissue, removal of tori, etc.

Note: If required documentation is not included, the requested services will be denied.

6. **MISSING TEETH:** Use an “X” to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
7. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL:** Indicate the teeth being replaced by the requested appliance and the teeth being clasped.
8. **NATURAL TEETH BEING RETAINED:** If teeth are being retained in the arch(es), indicate the treatment plan for the remaining teeth (root canals, periodontal treatment, restorative, crowns, etc.).
9. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the beneficiary, indicate whether the beneficiary wants the proposed services.
10. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the beneficiary to wear a prosthetic appliance. Document if the condition is temporary or permanent.
11. **ADDITIONAL COMMENTS:** Use this section for additional comments/documentation specific to the requested treatment.
12. **CONVALESCENT CARE:** If the beneficiary resides in a convalescent facility, document facility staff comments regarding the resident’s ability to benefit by or adapt to the requested treatment. The TAR should include the facility name, address, and phone number.
13. **SIGNATURE AND LICENSE NUMBER:** The dentist completing the form must sign the form and enter his/her dental license number.

Visit Denti-Cal at the California Dental Association Convention (CDA Presents) in San Francisco 2014

Be sure to visit the Denti-Cal booth at the [CDA Presents](#) in San Francisco, starting Thursday, September 4 through Saturday, September 6, 2014. Representatives from Denti-Cal will be on hand in Booth 825 of the Moscone South to provide current Denti-Cal information and answer questions regarding enrollment, restoration of some adult dental services, Electronic Data Interchange (EDI), provider training, and more!



In addition, the California Department of Health Care Services and Delta Dental of California will be presenting a seminar on the partial restoration of adult dental services for Denti-Cal beneficiaries. This course will focus on the treatment options and requirements of the newly re-established Denti-Cal services for adults. The course will also explain:

- common denial codes used by Denti-Cal in treatment authorization requests and claims,
- ways to reduce unnecessary denials through specific requirements for commonly billed procedures, and
- specific criteria for many of the common procedures that are restored services for adults in the Denti-Cal program.

For more details, visit the CDA website at: <http://www.cdapresents.com/SF2014.aspx>

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JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures, Resin Base Partial Dentures, Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Both arches must be evaluated and addressed. Chart missing teeth and teeth to be extracted. Complete each section of the form. Attach this form to the submitted TAR.

1 PATIENT: _____

2 DATE: _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE ITEM (TYPE OR PRINT CLEARLY)

MAXILLARY ARCH	MANDIBULAR ARCH
Appliance Requested: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD	Appliance Requested: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD
Existing Appliance: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD <input type="checkbox"/> Never had a maxillary prosthetic appliance	Existing Appliance: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD <input type="checkbox"/> Never had a mandibular prosthetic appliance
Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No Age of Appliance: _____	Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No Age of Appliance: _____
Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.	Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.
If lost in facility or hospital, explain circumstances: _____	If lost in facility or hospital, explain circumstances: _____

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:		Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	<input type="checkbox"/>	<input type="checkbox"/>	_____	Denture Base	<input type="checkbox"/>	<input type="checkbox"/>	_____
Framework	<input type="checkbox"/>	<input type="checkbox"/>	_____	Framework	<input type="checkbox"/>	<input type="checkbox"/>	_____
Denture Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Denture Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retention	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retention	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soft Tissue	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soft Tissue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hard Tissue	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hard Tissue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Opposing Dentition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Opposing Dentition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Centric Occlusion	<input type="checkbox"/>	<input type="checkbox"/>	_____	Edentulous <input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular			
Vertical Relation	<input type="checkbox"/>	<input type="checkbox"/>	Open _____ mm. Closed _____ mm	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16			
				32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17			
				X Block out missing teeth O Circle teeth to be extracted			

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH	MANDIBULAR ARCH
Teeth Being Replaced: _____	Teeth Being Replaced: _____
Teeth Being Clasped: _____	Teeth Being Clasped: _____

If treatment involves retaining teeth in the arch(es), indicate treatment plan for remaining teeth (Root canals, periodontal treatment, restorative, crowns, etc.): _____

8 Does the patient want requested services? No Yes

9 Does health condition of the patient limit dental adaptability? No Yes Explain: _____

10 ADDITIONAL COMMENTS: _____

11 CONVALESCENT CARE: Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver: _____

12 Provider Signature _____ License # _____

Reminder: Use the Appropriate Place of Service for Denti-Cal Beneficiaries Residing in Qualifying Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs)

Providers are reminded to use either Place of Service (POS) 4 or 5 when treating Denti-Cal beneficiaries residing in valid Skilled Nursing Facilities (SNFs) or Intermediate Care Facilities (ICFs) regardless of where they are treated.

When treating beneficiaries who reside in these facilities, providers are reminded of the following:

- ◆ Check the following web site for qualifying SNF and ICF facilities: <http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx>.
- ◆ All procedures, except for diagnostic or emergency procedures, require prior authorization when rendering treatment to facility beneficiaries, regardless of where the beneficiary is actually being treated.
- ◆ Prior authorizations for all procedures, except fixed partial dentures, removable prosthetics and implants, and laboratory processed crowns, will be waived for beneficiaries treated in a hospital or surgery center.

Include all of the following required documentation on the claim or TAR:

- ◆ When treating residents who reside in valid Skilled Nursing Facilities (SNF's) or Intermediate Care Facilities (ICF's) you must use either Place of Service (POS) 4 or 5 in Box 22 of the claim or TAR form regardless of where they are treated.
- ◆ Indicate the name, address, and phone number of the facility where the beneficiary actually resides in Box 34 of the claim or TAR form.
- ◆ When treating residents outside of the SNF/ICF facility, you must additionally indicate the name, address and phone number of the actual place where the service was performed in Box 34 of the claim or TAR form.

For additional information regarding clarification of services for beneficiaries residing in valid SNFs or ICFs, please refer to Bulletin [Volume 30, Number 10](#) and [Section 2 of the Provider Handbook \(Program Overview\)](#). If you have any questions, please contact the Provider Customer Service Line at (800) 423-0507.

Reminder: Current Dental Terminology (CDT) 13 Implementation and Procedure Code Changes

Denti-Cal would like to remind providers that, with the implementation of Current Dental Terminology Version 2013 (CDT-13), the following procedures and/or associated criteria have been changed in an effort to reduce paper work, reduce submission requirements, and expedite patient treatment.

Preventive

Procedures D1203 (Topical Application of Fluoride- Child) and D1204 (Topical Application of Fluoride- Adult) have been deleted and have been replaced with procedure D1208 (Topical Application of Fluoride). For dates of service prior to June 1, 2014 continue to submit procedures D1203 and D1204. For dates of service June 1, 2014 and after, submit procedure D1208 for all beneficiaries regardless of age.

Endodontic

There is no longer a requirement that endodontic treatment be completed before a laboratory processed crown can be requested for prior authorization. The request for endodontic treatment and laboratory processed crown can now be made on the same Treatment Authorization Request (TAR). Only the pre-operative radiograph and arch films are required to be submitted with the TAR. Please note that arch films are not required for patients under the age of 21.

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Periodontal

The requirement to submit documentation of a definitive periodontal diagnosis and a periodontal evaluation chart has been eliminated for all periodontal procedures. However, this documentation must be kept in the patient's treatment record.

Prosthodontics

Prior authorization and the submission of radiographs for immediate dentures (procedures D5130 and D5140) have been eliminated. However, prior authorization is still required for beneficiaries residing in a State certified Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

As a reminder, Denti-Cal defines an immediate denture as a complete denture that requires extractions. There must be evidence of recent extractions within six months of the date of service of the denture.

Copies of the new MOC and SMA are available for review on the Denti-Cal web site in the "[What's New](#)" section. **Please note that providers must continue to use the CDT-11-12 codes currently listed in the MOC (dated April 2, 2012) for rendered services with dates of service prior to the June 1, 2014 effective date.**

More information about the CDT 13 transition can be found in Bulletin Volume 30, Number 6 and by calling the Provider Customer Service Line at 1-800-423-0507.

No Claim Activity

Providers who have not submitted a claim for reimbursement from the Medi-Cal program for one year shall be deactivated per Welfare and Institutions Code Section 14043.62 (a), which reads as follows:

The department shall deactivate, immediately and without prior notice, the provider's number, including all business addresses used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you have not had any claim activity in a 12-month period, and wish to remain an active provider in the Denti-Cal Program, please complete the No Claim Activity form attached to this bulletin and mail it to:

**Denti-Cal
California Medi-Cal Dental Program
PO Box 15609
Sacramento, CA 95852-0609**

If your provider number is deactivated, you must reapply for enrollment in the Denti-Cal Program. To request an enrollment package contact Denti-Cal toll-free at (800) 423-0507, or download the Denti-Cal application forms from the Denti-Cal website at www.denti-cal.ca.gov.



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