

Denti-Cal California Medi-Cal Dental Bulletin

March 2014
Volume 30, Number 5

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Training Seminars

Reserve your spot for one of our training seminars.

Burbank
Basic & EDI/D471 - Mar. 5, 2014
Advanced/D472 - Mar. 6, 2014

Webinar
Basic & EDI/D473 - Mar. 14, 2014

Culver City
Basic & EDI/D474 - Mar. 5, 2014
Advanced/D475 - Mar. 6, 2014

Provider Enrollment Assistance Line

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

Wednesday, March 19,
8 am - 4 pm.

Annual Denti-Cal Referral List Refresh

Providers who were added to the Denti-Cal referral list prior to December 1, 2013 and who wish to remain on the list will be required to submit a new [Medi-Cal Dental Patient Referral Service Form](#). Upon receipt of a notification, providers will have 35 business days to complete and submit the form. Providers who do not submit the form will be removed from the referral list.

There are several options for completing and returning the form:

- Electronically submit the completed [Medi-Cal Dental Patient Referral Service Form](#) and click the "Submit by Email" option
- Mail the form to Denti-Cal in the postage paid envelope provided
- Fax the form to the Denti-Cal Provider Services fax number at 916-631-0672
- Call the Provider Customer Service Line at 1-800-423-0507, to have a representative assist you with completing the form

This referral service is 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 Medi-Cal beneficiaries. Thank you for your continued support and participation as we strive to improve oral health for thousands of California Medi-Cal beneficiaries.

Some Adult Dental Services to be Restored in 2014

On June 27, 2013, Governor Jerry Brown approved Assembly Bill 82 (AB 82) which restores some adult dental benefits to the Denti-Cal program. Beginning May 1, 2014, the following benefits will be restored to beneficiaries age 21 and older:

- Initial examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

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- Amalgam and composite restorations.
- Prefabricated stainless steel, resin, and resin window crowns.
- Anterior root canal therapy.
- Complete dentures, including immediate dentures.
- Complete denture adjustments, repairs, and relines.

For the following, adult dental benefits remain in place and do not change as a result of the partial restoration of adult benefits: pregnancy-related services, emergency services, Federally Required Adult Dental Services, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for the Department of Developmental Services consumers. Please refer to the Provider Handbook for further information regarding these benefits.

Please check the Denti-Cal web site frequently for future updates and clarifications. For questions, please call the Customer Service Line at 1-800-423-0507.

Providing and Billing Anesthesia Services for Denti-Cal Beneficiaries

Anesthesia Record Requirements

For general anesthesia (D9220 and D9221) and intravenous conscious sedation/analgesia (D9241 and D9242), an Anesthesia Record must be submitted with the request for payment. The Anesthesia Record must include:

- Signature of the enrolled provider performing the analgesia procedure.

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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, March 13, 2014 8:00 AM- 4:00 PM	Hilton Oakland Airport One Hegenberger Road Oakland, CA 94621 (510) 635-5000	Alameda
Register Now!		
Thursday, March 27, 2014 8:00 AM- 4:00 PM	Hilton San Diego/Del Mar 15575 Jimmy Durante Blvd. Del Mar, CA 92014 (858) 792-5200	Orange
Register Now!		

Note: This enrollment workshop will be held at the same location as the Denti-Cal Basic & EDI seminar.

- Rendering provider's name printed legibly.
- Rendering provider's permit number printed legibly.
- Anesthesia start and stop time.
- Drugs administered.

Permit Requirements

The dental anesthesiologist or the dentist providing anesthesia/analgesia services must be permitted or certified through the Dental Board of California per Business and Professions Code 1646.1 and 1647.19-.20.

If you would like to know the status of a provider's ability to provide anesthesia/analgesia services and/or would like to apply to be able to perform such procedures, please visit the Dental Board of California website at: www.dbc.ca.gov or call the Dental Board of California at 877-729-7789 (Toll Free).

Enrollment

Billing providers **must** ensure that all their providers (dental anesthesiologists and dentists) rendering general anesthesia and intravenous conscious sedation/analgesia have:

- Enrolled in the Denti-Cal program prior to treating Medi-Cal patients. Payments made to billing providers for services performed by unenrolled rendering providers will be subject to payment recovery per Title 22 Section 51458.1(a)(6).
- Permit numbers must be on file with Denti-Cal.

Instructions about enrolling in the Denti-Cal program are found in the [Provider Handbook, Section 3: Enrollment Requirements](#).

To obtain an application packet, contact Denti-Cal at (800) 423-0507 or visit the Denti-Cal Web site to download the application forms:

<http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=ApplicationForms>

Billing

When billing Denti-Cal for general anesthesia (D9220 and D9221) or intravenous conscious sedation/analgesia (D9241 and D9242), you must properly identify the dentist administering general anesthesia or intravenous conscious sedation/analgesia as the rendering provider by providing their National Provider Identification (NPI) in field 33 as the rendering provider. **This must be the rendering provider's NPI who administered the anesthesia.** Instructions for filling out claim forms accurately can be found in the [Provider Handbook, Section 6: Forms](#).

Additionally, the proof of Medi-Cal eligibility must be accepted as payment in FULL except where share of costs are allowed, and no additional compensation may be demanded or collected per Welfare and Institutions Code 14019.3(d) and Title 22 Section 51002.

Clarification of Procedures for Denti-Cal Beneficiaries Residing in Qualifying Skilled Nursing Facilities and Intermediate Care Facilities

With the restoration of some adult dental services in 2014, providers are reminded that there will be no changes to services for residents of qualifying Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF). These beneficiaries will continue to have full scope benefits.

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

- Check the following website 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 rendered to facility beneficiaries, regardless of where the beneficiary is actually being treated.

- Prior authorization will be waived for beneficiaries treated in a hospital or surgical center with the exception of fixed partial dentures, removable prosthetics and implants. When billing for services rendered in a hospital or surgical center:
 - Indicate in Box 34 or the Comments field if submitting electronically, that the beneficiary was treated in a hospital or surgery center.
 - Attach all required documentation and radiographs/photographs.

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

- Use place-of-service 4 (SNF) or 5 (ICF) only, regardless of where the beneficiary is being treated.
- In Box 34 enter:
 - Name, address and phone number of the facility where the beneficiary resides.
 - Name, address and phone number of the place where the service was rendered.

If a provider receives a denial on a claim for a beneficiary who resides in a qualifying licensed SNF or ICF, the provider can submit a Claim Inquiry Form (CIF). If the services were denied on a Treatment Authorization Request (TAR), the provider can submit a Notice of Authorization (NOA) and request re-evaluation. The CIF and NOA must include the facility name, address, phone number, and all necessary radiographs, photographs and documentation must be submitted to have the services on the NOA re-evaluated.

Adult Dental Services for Department of Developmental Services Regional Center Consumers

With the restoration of some adult dental services in 2014, providers are reminded that there will be no changes to existing services for regional center consumers (also known as Department of Developmental Services (DDS) beneficiaries or consumers of DDS) age 21 and over. These beneficiaries will continue to have full scope benefits and are exempt from the \$1,800 annual dental cap. Dental providers providing services to regional center consumers must be enrolled in the Denti-Cal program to be reimbursed by Denti-Cal.

Dental services for regional center consumers will be authorized/paid in accordance with existing Denti-Cal policies, procedures, and requirements.

Providers can contact the Denti-Cal Telephone Service Center at 1-800-423-0507 to verify eligibility for regional center consumers.

The Centers for Medicare & Medicaid Services Salutes National Children's Dental Health Month (NCDHM)-Week 2

In modern dentistry, we are fortunate to help improve health for pregnant women and even their unborn children. While many myths about treating pregnant women have surfaced over the years, most are now proven to be unfounded. Treating women during pregnancy is safe for the patient and her unborn child and important to the health of both.

Good oral health is important not only for growth and development of the fetus, but also for the mother's general health. Much has been written about a connection between periodontal diseases and preterm, low birth weight babies. While a cause and effect has not been proven, we do know that infection anywhere in the body, including dental infections, can have consequences for the unborn child. Because another issue is the possible maternal transmission of cariogenic bacteria from mother to infant, the mother's excellent dental health gives her baby the best opportunities for oral health. Keeping the expectant mother at optimum oral health can benefit her child's health for a lifetime.

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Dental care, including restorative as well as preventive and diagnostic care, is not only important during pregnancy, it is safe. Radiographic technique, which should always employ proper barriers, continues to be safe during pregnancy. Use of local anesthetics, including those with vasoconstrictors, is also safe and appropriate for needed restorative or surgical treatment.

Be aware of special considerations for pregnant patients. During later months of their pregnancy, pay attention to chair positioning that will make them as comfortable as possible. Be sure to help them understand the vital importance of daily oral hygiene to prevent gingivitis and to avoid the complications of gestational diabetes. Also, be aware of conditions that may arise due to their pregnancy, including pyogenic granulomas, a condition usually needing no treatment but that may be disconcerting to the patient.

Our medical colleagues are advised to include an oral health assessment during prenatal evaluations, and refer patients to dentists as appropriate. During that assessment, we would hope they not only ask about gingival bleeding or oral pain, but also reinforce the need for dental care during this important time. It is even more important to maintain open communication between dentist and physician during a woman's pregnancy.

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Dental benefits for pregnant women under Medicaid and the Children's Health Insurance Program (CHIP) vary from state to state. If the woman is under age 21, she may be eligible for dental coverage under Medicaid's child and adolescent benefit, often referred to as the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) program. In addition, some states have dental benefit provisions especially for pregnant women and others may offer benefits for all adults. Please check with your state Medicaid agencies or the Marketplace for further information on coverage.

CMS has produced oral health education materials especially for pregnant women and parents of young children. The "Think Teeth" materials provide basic information on oral health during pregnancy and children's need to be seen by the dentist starting at age one or eruption of the first teeth. The posters and "tear sheets," available in English and Spanish, are available for free through the Insure Kids Now website at <http://insurekidsnow.gov/professionals/dental/index.html>

For further information on oral health care during pregnancy, check out the resource "Oral Health Care During Pregnancy: A National Consensus Statement" online at the Maternal and Child Health Oral Health Resource Center at: <http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf>

Lynn Douglas Mouden, DDS, MPH, FICD, FACD

Dr. Mouden, with almost 40 years of background in private practice and dental public health, now serves as Chief Dental Officer for the Centers for Medicare & Medicaid Services.

The Centers for Medicare & Medicaid Services Salutes National Children's Dental Health Month (NCDHM) -Week 4

Why is oral health care usually viewed as separate from traditional medical care? For reasons not easily understood, oral health care and medical care are not thought of as connected. Think about "health" insurance and you will probably find that everything above the hyoid bone has not necessarily been included. Other than the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children and adolescents in Medicaid and CHIP which provides dental, vision, hearing and mental health, the majority of private insurance usually offered these as optional benefits, at additional cost.

The reason may be based in the founding, in 1840, of the first dental school, The Baltimore College of Dental Surgery. Prior to the founding of the dental school, dentistry was considered a specialty of medicine, with students first completing medical education, and then specializing in dentistry, sometimes referred to as "stomatology." Separating dental education from medical education may have led, in part, to separating the mouth from the rest of the body.

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Use of Claim Inquiry Forms

A Claim Inquiry Form (CIF) can be used to:

1. Request the re-evaluation of a denied claim or Notice of Authorization (NOA); and
2. Inquire about the status of a Treatment Authorization Request (TAR) or claim.



Claim re-evaluations must be received within six (6) months from the date outlined on the Explanation of Benefits (EOB). Providers should submit any additional radiographs and documentation pertinent to the procedure for reconsideration.

Providers should wait until the status of a processed claim appears on the EOB prior to submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the “Adjusted Claims” section.

A CIF tracer is used to request the status of a TAR or claim. Providers should wait one month before submitting a CIF tracer to allow enough time for the document to be processed. If, after one month, the claim or TAR has not been processed or has not appeared in the “Documents In-Process” section of the EOB, then a CIF tracer should be submitted.

Denti-Cal will respond to a CIF with a Claim Inquiry Response (CIR). Use a separate CIF for each claim, TAR or NOA in question.

Note: Do not use the CIF to request a first level appeal. Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Denti-Cal Telephone Service Center at 1-800-423-0507.

Fortunately, in recent years the medical and dental community are building bridges across these two important fields – and noting that this bridge should be a two-way street. Our medical colleagues usually see infants in their offices well before the recommended age one dental visit. This provides a perfect opportunity to assess oral health as a routine part of the infant’s or child’s physical exam.

Our medical colleagues understand that the mouth and teeth are a fundamental part of keeping their patients healthy. New billing codes (CDT 0190 and 0191) allow reimbursement for screenings and assessments when performed by physicians or other non-dental professionals. It is our hope that states will use these procedure codes in various settings to go beyond the oral assessment that is part of the well-child exam and conduct a risk assessment on children at risk of dental caries, and more importantly, refer them to dental providers for dental care.

In addition to screening for oral health status, medical providers can also apply fluoride varnish to a child’s teeth, as appropriate, and many state Medicaid and CHIP programs will train and reimburse physicians for this service. As dental providers, we should support these collaborative efforts that lead to healthier mouths and better health for children.

Dental-medical collaboration also occurs when dental professionals work with our medical colleagues for consultation and care coordination. Dentistry does not presume to treat diabetes or hypertension, but we must work with our patients’ other health care professionals to ensure that the patient is receiving the most appropriate care – care that moves the patient toward better health. Careful review of the patient’s health history and medications will help us understand how dental care can be tailored to specific chronic, as well as acute conditions, without compromising medical treatment.

We at CMS thank you for taking time to help us celebrate National Children’s Dental Health Month (NCDHM). We have highlighted just a few issues in dental care to raise awareness about oral health, and to join our many national, state and local partners in celebrating NCDHM. Within our Center for Medicaid and CHIP Services, we celebrate children’s oral health every month. Help us continue that celebration for children, as well as adults and seniors, for those who are disadvantaged in accessing health care, and for those with special needs. We and our many health provider partners across the country have the opportunity to improve health every day – and yes, that does include oral health.

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Dr. Mouden, with almost 40 years of background in private practice and dental public health, now serves as Chief Dental Officer for the Centers for Medicare & Medicaid Services.

Updated 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):
 1. Denti-Cal authorized treatment on a 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.
 2. Orthodontic coverage is a benefit to age 21 for qualifying beneficiaries. Authorized orthodontic treatment may be rendered on an eligible beneficiary through the month of their 21st birthday.
- All Denti-Cal forms submitted on paper: 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 the attachment box (Field 10). Submit all required documentation and/or radiographs. Do not submit a Claim Inquiry Form (CIF) for this purpose.
- Please do not send a new claim for payment of authorized services. Send the original NOA in for payment.
- Arch radiographs are defined as a combination of radiographs that best depicts the condition of the remaining teeth in the arch. Arch radiographs 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.
- When submitting digitized radiographs and photographs, include the "image created date" which should be the date the images were taken in the office.

Common Adjudication Reason Code (ARC) Denials

The most common adjudication reason code denials are as follows:

- Not submitting the required radiographs for restorations and extractions (ARC 266B).
- Submitted third molar extractions do not meet the program guidelines (ARC 048).
- Mislabeled radiographs and photographs (including digitized images):
 - 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 does not match the date of service indicated on the claim for the photographs (ARC 031D).
 - Radiographs/photographs are not labeled right/left or teeth numbers are not indicated (ARC 266G).
- Submitting non-diagnostic radiographs (ARCs 266C, 266I, 266K).
- Providers are not responding to RTDs or if the document was sent electronically, requests for radiographs/attachments (ARC 326).
- Submitting incorrect tooth numbers, surfaces or procedure codes (ARC 260, 261, 261A).

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- 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 (ARC 319/319A).
- 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.