November 2016

Dear Denti-Cal Provider:

Enclosed is the most recent update of the Medi-Cal Dental Program Provider Handbook (Handbook). The pages reflect changes made to the Denti-Cal program during the month of November 2016. These changes are indicated with a vertical line next to the text.

The following list indicates the pages that have been updated for the Fourth quarter Handbook release. Previously released bulletins can be found on the "Denti-Cal Provider Bulletins" page of the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

Remove These Pages	Insert These Pages
Letter to Doctor	
Entire Section	Entire Section
How To Use This Handbook	
Entire Section	Entire Section
Section 12 - Denti-Cal Bulletin Index	
Entire Section	Entire Section

Thank you for your continual support of the Medi-Cal Dental Program. If you have any questions, please call (800) 423-0507.

Sincerely,

DENTI-CAL

CALIFORNIA MEDI-CAL DENTAL PROGRAM

November 2016

Dear Doctor:

We are pleased to provide you with the Medi-Cal Dental Program Provider Handbook ("Handbook").

The purpose of this Handbook is to give dental care professionals and their staff a concise explanation of billing instructions and procedures under the California Medi-Cal Dental (Denti-Cal) Program. It is designed to assist you in your continued participation in the Denti-Cal Program.

We trust you will find the Handbook useful and that it will be maintained as a working document. Please do not hesitate to visit the Denti-Cal Web site at http://www.denti-cal.ca.gov/ or call upon Denti-Cal for further assistance.

Sincerely,

Alani Jackson, MPA
Division Chief
Medi-Cal Dental Services Division
Department of Health Care Services

Joe Ruiz, Vice President
State Government Programs, Denti-Cal
California Medi-Cal Dental Program
Delta Dental of California

Preface

This Handbook contains basic information about Denti-Cal. It is designed to provide detailed information concerning Denti-Cal policies, procedures and instructions for completing the necessary forms and other related documents.

The criteria and policies contained in this Handbook are subject to the provisions of the Welfare and Institutions (W & I) Code and regulations under California Code of Regulations (CCR), Title 22. When changes in these criteria and/or policies occur, bulletins and revised pages will be issued for purposes of updating the information in this Handbook.

Please call the Denti-Cal toll-free number, (800) 423-0507, with any questions you have regarding the contents of this Handbook or participation in the California Medi-Cal Dental Program. Our Provider Services staff will be happy to assist you.

Copies of this Handbook, and other valuable information, can be found on the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

How to Use This Handbook

This Handbook is your primary reference for information about the Denti-Cal Program, as well as submission and processing of all necessary documents. The Handbook contains detailed instructions for completing Denti-Cal claims, Treatment Authorization Requests, Resubmission Turnaround Documents, Claim Inquiry Forms and other billing forms for dental services, and should be consulted before seeking other sources of information.

The Handbook is organized into 13 major sections:

- Section 1 - Introduction
- Section 2 - Program Overview
- Section 3 - Enrollment Requirements
- Section 4 - Treating Beneficiaries
- Section 5 - Manual of Criteria and Schedule of Maximum Allowances
- Section 6 - Forms
- Section 7 - Codes
- Section 8 - Fraud, Abuse and Quality of Care
- Section 9 - Special Programs
- Section 10 - CDT 13 Tables
- Section 11 - Glossary
- Section 12 - Denti-Cal Bulletin Index
- Section 13 - Index

The Table of Contents provides an overview of all major sections and subsections in the Handbook.

Bulletin information released from December 2015 through November 2016 has been incorporated into the Handbook. Please refer to the Denti-Cal Bulletin Index for the page where the information may be found.

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Section 1 - Introduction

Program Background

In July 1965, two important amendments to the Social Security Act greatly expanded the scope of medical coverage available to much of the population. Title XVIII established the Medicare program, and Title XIX created the optional state medical assistance program known as Medicaid. This legislation also provided for the federal government to match funds for states electing to implement a comprehensive health care program.

In November 1965, legislation was signed to implement the Title XIX program in the State of California, called "Medi-Cal." A dental segment of this program was subsequently established. Initially, benefits provided under the California Medi-Cal Dental (Denti-Cal) Program were approved by the State and paid by Blue Shield of California as fiscal intermediary. Since January 1, 1974, Delta Dental of California has administered the Denti-Cal Program for the State of California, Department of Health Care Services.

Over the years, the Denti-Cal program has undergone several changes. Legislation in 1991 brought about reduced documentation and prior authorization requirements for many common procedures, increased the fees paid to providers for these services, and expanded outreach activities to promote greater access to dental care for all Medi-Cal beneficiaries. The Denti-Cal program has also seen the creation of an orthodontic benefits program for beneficiaries with handicapping malocclusion, cleft palate and craniofacial anomalies. The scope of available services for children was widened with the addition of dental sealants as a covered benefit.

Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) added Section 14131.10 to the Welfare and Institutions Code, eliminated most dental services for adults 21 years and older. Dental services that are still benefits for adults are: Federally Required Adult Dental Services (FRADS), dental services for pregnant beneficiaries for treatment of conditions that might complicate the pregnancy, dental services that are necessary as either a condition precedent to other medical treatment or in order to undergo a medical surgery, and dental services provided to beneficiaries who reside in a licensed Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Effective May 1, 2014, Assembly Bill 82 (AB 82) restored some dental benefits for adults 21 years and older: Restored Adult Dental Services (RADS). Please see "Table 3: Restored Adult Dental Services (RADS)" in "Section 10 -CDT 13 Tables."

Innovative program enhancements such as electronic funds transfer of Denti-Cal payments and electronic claims submission continue to bring Denti-Cal to the forefront as one of the most advanced systems of subsidized dental health care delivery in the United States.

Program Objectives

The primary objective of the Denti-Cal Program is to create a better dental care system and increase the quality of services available to those individuals and families who rely on public assistance to help meet their health care needs. Through expanding participation by the dental community and efficient, cost-effective administration of the Denti-Cal Program, the goal to provide quality dental care to Medi-Cal beneficiaries continues to be achieved.

Regulations

Denti-Cal is governed by policies subject to the laws and regulations of the Welfare and Institutions (W & I) Code, the California Code of Regulations (CCR), Title 22, and the California Business and Professions Code - Dental Practice Act. For additional information, visit these web sites:

- **W & I Code**: http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic&codebody=&hits=20
- **California Code of Regulations (CCR), Title 22**: http://government.westlaw.com/linkedslice/default.asp?SP=CCR-1000

- **California Business and Professions Code**: http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=bpc&codebody=&hits=20#Chapter%204
- **Denti-Cal** (click on the Statutes and Regulations tab): http://www.denti-cal.ca.gov/

Current Dental Terminology (CDT) Copyright

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Section 2 - Program Overview

Provider Participation in the California Medi-Cal Dental (Denti-Cal) Program

To receive payment for dental services rendered to Medi-Cal beneficiaries, prospective providers must apply and be approved by Denti-Cal to participate in the Denti-Cal Program, the details of which are found in "Section 3: Enrollment Requirements" of this Handbook. When a provider is enrolled in the Denti-Cal program, Denti-Cal sends the provider a letter confirming the provider's enrollment effective date. Denti-Cal will not pay for services until the provider is actively enrolled in the Denti-Cal Program.

Compliance in the Denti-Cal Program

California Code of Regulations (CCR), Title 22, Section 51476, requires participants in the Denti-Cal program to:

1. Comply with Title VI of the Civil Rights Act of 1964 (PL 88-352), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and all requirements imposed by the Department of Health and Human Services (DHHS) (45 CFR Part 80), which states that "no person in the United States shall, on the ground of race, color, religion, sex, age, disability, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives state financial assistance from the Department." Additionally, providers must comply with California Department of Corporations laws and regulations, which forbid discrimination based on marital status or sexual orientation (Rule 1300.67.10, California Code of Regulations).
2. Keep and maintain all records disclosing the type and extent of services provided to a beneficiary for a period of three years from when the service was rendered (W & I Code, Sections 14124.1 and 14124.2).
3. Provide all pertinent records to any authorized representative of the state or federal government concerning services rendered to a beneficiary (California Code of Regulations (CCR), Title 22, Section 51476(g)).
4. Not bill or collect any form of reimbursement from beneficiaries for services included in the Denti-Cal program scope of benefits, with the exception of Share of Cost (California Code of Regulations (CCR), Title 22, Section 51002).
5. Certify:
   - the services listed on the Treatment Authorization Request (TAR)/Claim form have been provided to the beneficiary either by the provider or another person eligible under the Medi-Cal program to provide such services. Such person(s) must be designated on the treatment form.
   - the services were necessary to the health of the beneficiary.
   - that he or she understands payment for services rendered will be made from federal and/or state funds and that any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.

Failure to comply with Dent-Cal program requirements will result in corrective actions. Please see "Section 8: Fraud, Abuse and Quality of Care" of this Handbook for more information.

Out-of-State Coverage

Out-of-state providers who wish to be reimbursed by Denti-Cal for services provided to California Medi-Cal beneficiaries are subject to specific regulations under California Code of Regulations (CCR), Title 22, Section 51006, Out-of-State Coverage. The regulations state:

(a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:

(1) When an emergency arises from accident, injury or illness; or

(2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or

(3) Where the health of the individual would be endangered if he undertook travel to return to California; or

(4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or

(5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State.

(6) Prior authorization is required for all out-of-state services, except:

(A) Emergency services as defined in Section 51056.

(B) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.

(b) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

More information on Out-of-State Coverage is found on the Administrative Law Web site: http://www.oal.ca.gov/.

Written Correspondence

Most provider inquiries can be answered by using the automated system or operator-assisted options that are available through the toll-free telephone line. For protection and confidentiality, Denti-Cal requires that certain inquiries and requests be made through written correspondence only. The types of inquiries and requests that must be sent to Denti-Cal in writing include:

- a change or correction to a provider's name/address or other information concerning a dental practice;
- a request for a detailed printout of a provider's financial information, such as year-to-date earnings;
- a change in electronic funds transfer information, such as a different banking institution or new account number;
- a request to stop payment of or reissue a lost or stolen Denti-Cal payment check.

All written inquiries and requests should contain at a minimum the following information:

- provider name
- Denti-Cal billing provider number
- date of request/inquiry
- signature of billing provider

Written correspondence should also include any other specific information that pertains to an inquiry or request.

Direct all written correspondence to:

Denti-Cal
Attn: [Name of Department]
PO Box 15609
Sacramento, CA 95852-0609

Upon receipt of written correspondence, the provider will receive acknowledgement that the request has been received by Denti-Cal and is being processed.

Suspended and Ineligible Providers

Billing providers who submit claims for services provided by a rendering provider suspended from participation in the Denti-Cal Program are also subject to suspension from the Program.

Welfare and Institutions (W & I) Code, §14043.61(a) states that "a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies, or merchandise provided, directly, or indirectly, to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List,…or any list is published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers."

The List of Excluded Individuals/Entities compiled by the Office of Inspector General is available online at: http://exclusions.oig.hhs.gov.

Enrollment Denied for Failure to Disclose Fraud or Abuse, or Failure to Remediate Deficiencies

Per Assembly Bill 1226 (Chaptered October 14, 2007, amending Sections 14043.1, 14043.26, and 14043.65 of the Welfare and Institutions Code):

A provider whose application for enrollment is denied for failure to disclose fraud or abuse, or failure to remediate deficiencies after Department of Health Care Services (DHCS) has conducted additional inspections, may not reapply for a period of three years from the date the application is denied. Three-year debarment from the Medi-Cal program would begin on the date of the denial notice.

Applicants are allowed 60 days to resubmit their corrected application packages when DHCS returns it deficient.

General Telephone Information

Provider Toll-Free Telephone Number

For information or inquiries, providers may call Denti-Cal toll-free at (800) 423-0507. Providers are reminded to have the appropriate information ready when calling, such as:

1. Beneficiary Name
2. Beneficiary Medi-Cal Identification Number
3. Billing Provider Name
4. Provider Number
5. Type of Treatment
6. Amount of Claim or TAR
7. Date Billed
8. Document Control Number
9. Check Number

Telephone Service Center Representatives are available Monday through Friday between 8:00 a.m. and 5:00 p.m., excluding holidays. Providers are advised to call between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m., when calls are at their lowest level.

Hours of operation and additional information for the Interactive Voice Response (IVR) system can be found in "Section 4: Treating Beneficiaries" of this Handbook.

In order for Denti-Cal to give the best possible service and assistance, please use the Denti-Cal Provider toll-free number: (800) 423-0507.

Inquiries that cannot be answered immediately will be routed to a telephone inquiry specialist. The question will be answered by mail within 10 days of the receipt of the original telephone call.

Beneficiary Toll-Free Telephone Number

If an office receives inquiries from beneficiaries, please refer them to the Denti-Cal Beneficiary Services toll-free number: (800) 322-6384

The Beneficiary Services toll-free lines are available from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding holidays.

Either beneficiaries or their authorized representatives may use this toll-free number. Beneficiary representatives must have the beneficiary's name, BIC or CIN and a signed Release of Information form on file with Denti-Cal in order to receive information from the Denti-Cal program.

The following services are available from the Denti-Cal program by Beneficiary Services toll-free telephone operators:

1. A referral service to dentists who accept new Denti-Cal beneficiaries
2. Assistance with scheduling and rescheduling Clinical Screening appointments
3. Information about SOC and copayment requirements of the Denti-Cal Program
4. General inquiries
5. Complaints and grievances
6. Information about denied, modified or deferred Treatment Authorization Requests (TARs)

Contact Listings for Denti-Cal

Denti-Cal Program - Contact the Denti-Cal Program for questions related to payments of claims and/or authorizations of Treatment Authorization Requests (TARs).	
Provider Toll-Free Line	(800) 423-0507
Beneficiary Toll-Free Line	(800) 322-6384
Teletext Typewriter (TTY)	(800) 735-2922
Electronic Data Interchange (EDI) Support: denti-caledi@delta.org	(916) 853-7373
Conlan Help Desk	(916) 403-2007
Denti-Cal Program Abuse Line	(800) 822-6222

Ordering Denti-Cal Forms	**Provider First Level Appeal**	**Written Correspondence**
Denti-Cal Forms Reorder 11155 International Dr., MS C210 Rancho Cordova, CA 95670 FAX: (877) 401-7534	Denti-Cal Attn: Appeals Unit PO Box 13898 Sacramento, CA 95853-4898	Attn: [Name of Department] PO Box 15609 Sacramento, CA 95852-0609

Medi-Cal Program - Contact the Medi-Cal Program for California Children's Services (CCS)/Medi-Cal, Genetically Handicapped Persons Program (GHPP)/Medi-Cal, CCS-only, and CCS/Health Families (HF) eligibility, Point of Service (POS), or Internet questions.	
Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk, POS, and/or Internet Help Desk	(800) 541-5555
Outside California	(916) 636-1200
Internet Eligibility Web Site: http://www.medi-cal.ca.gov/	
Attorney General's Medi-Cal Fraud Hotline	(800) 722-0432

GHPP State Office - Providers are to contact this State office for GHPP-only related questions.	
Genetically Handicapped Persons Program MS 8200 PO Box 997413 Sacramento, CA 95899	(916) 327-0470 or (800) 639-0597 FAX: (916) 327-1112
County Medical Services Program (CMSP) Questions Regarding Changes to Program: http://www.cmspcounties.org/	(916) 649-2631
Beneficiary State Hearings/To Withdraw from a State Hearing State Hearings Division PO Box 944243, MS: 19-37 Sacramento, CA 94244-2430	(855) 266-1157

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Internet Access and Web Sites

The Denti-Cal web site (http://www.denti-cal.ca.gov/) now meets increased usability and accessibility standards, and has been improved to allow for faster navigation to important topics and provider resources. A new search engine makes finding information fast and easy.

Both the Denti-Cal and Medi-Cal Web sites (http://www.medi-cal.ca.gov/) are available 24 hours/day, seven days/week. The latest versions of free browsers and other tools, such as Adobe Acrobat, may be accessed through the Web sites toolbox link. Both Web sites provide links to other sites with useful and related information.

The Denti-Cal Web site provides access to:

- provider and Electronic Data Interchange (EDI) enrollment descriptions and forms
- access to resource links
- publications, such as bulletins and Handbook updates
- seminar schedules
- the provider referral list
- information related to billing criteria
- outreach services
- managed care
- frequently asked questions.

The Medi-Cal Web site allows providers to:

- access eligibility
- perform Share of Cost (SOC) transactions

More information about SOC can be found in "Section 4: Treating Beneficiaries" of this Handbook.

E-Mail

Providers can now subscribe to the Denti-Cal Provider E-mail List to receive updates related to the Denti-Cal program. A registration form is available on the Denti-Cal website. Providers may unsubscribe from the e-mail list at any time.

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Training Program

Denti-Cal offers an extensive training program that has been designed to meet the needs of both new and experienced providers and their staffs.

Seminars

Denti-Cal conducts basic and advanced seminars statewide. Seminar attendees receive the most current information on all aspects of the Denti-Cal Program. Basic seminars address general program purpose, goals, policies and procedures; provide instructions for the correct use of standard billing forms; and explain the reference materials and support services available to Denti-Cal providers. The expanded format of the advanced seminars offers in-depth information on topics such as Medi-Cal Identification Cards; dental criteria; radiograph and documentation requirements; processing codes; and other topics of specific concern to Denti-Cal providers.

In addition to the regular basic and advanced seminars scheduled each quarter, Denti-Cal conducts workshops and orthodontic specialty seminars throughout the year. The uniquely designed workshops give inexperienced billing staff a "hands-on" opportunity to learn about the Denti-Cal program and practice their newly acquired skills. Specialized training seminars have been developed for orthodontists who participate in the Denti-Cal Orthodontic Services Program; these intensified sessions cover all aspects of the Denti-Cal orthodontic program, including enrollment and certification, completion of billing forms, billing procedures and criteria and policies specific to the provision of Denti-Cal orthodontic services.

Each Denti-Cal training seminar is conducted by an experienced, qualified instructor.

Continuing education credits for all seminars are offered to dentists and registered or certified dental assistants and hygienists. Denti-Cal training seminars are offered free of charge at convenient times and locations.

Although there are no prerequisites for attendance at any type of seminar, in order for Denti-Cal to continue offering free provider training seminars and workshops, making reservations well in advance is recommended. If unable to keep the reservation, please notify Denti-Cal promptly. Space is limited and "no-shows" prevent others from being able to attend. Seminar schedules are available on the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

On-Site Visits

Providers needing assistance may request an on-site visit by a Provider Relations Representative by phoning the Denti-Cal Telephone Service Center: (800) 423-0507. This personal attention is offered to help the provider and office staff better understand Denti-Cal policies and procedures to easily meet program requirements.

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Provider Appeals Process

The three separate, specific procedures for asking Denti-Cal to reevaluate/appeal the denial or modification of a claim payment or a TAR authorization are as follows:

1. Submitting a Claim Inquiry Form (CIF)
2. Reevaluation of a Notice of Authorization (NOA)
3. First–Level appeal

To find out why payment of a claim was disallowed or to furnish additional information to Denti-Cal for reconsideration of a payment denial or modification, the provider should begin by submitting the Claim Inquiry Form (CIF) within six calendar months of the Explanation of Benefits (EOB) date. Please refer to "Section 6: Forms" of this Handbook for guidelines for submitting a CIF. Check the box on the CIF marked "CLAIM REEVALUATION ONLY." Remember to send a separate CIF for each inquiry.

Use the Notice of Authorization (NOA) to request a single reevaluation of modified or disallowed procedures on a TAR. Check the "Reevaluation is Requested" box in the upper right corner of the NOA. Do not sign the NOA when requesting reevaluation. Include any additional documentation for reconsideration and return the NOA to Denti-Cal. Reevaluations may be requested only once. In "Section 6: Forms" of this Handbook, the complete procedures is listed for requesting reevaluation of a TAR using the NOA.

If upon reconsideration Denti-Cal upholds the original decision to disallow payment of the claim or authorization of treatment, the provider may request an appeal. In accordance with Title 22, Section 51015, of the California Code of Regulations (CCR), Denti-Cal has established an appeals procedure to be used by providers with complaints or grievances concerning the processing of Denti-Cal TAR/Claim forms for payment. The following procedures should be used by dentists to appeal the denial or modification of a TAR or claim for payment of services provided under the Denti-Cal Program:

Provider First-Level Appeals

1. The provider must submit the appeal by letter to Denti-Cal within 90 days of the EOB denial date. Do not use CIFs for this purpose.
2. The letter must specifically request a first-level appeal.
3. Send all information and copies to justify the request. Include all documentation and radiographs.
4. The appeal should clearly identify the claim or TAR involved and describe the disputed action.
5. First-level appeals should be directed to:
   Denti-Cal
   Attn: Provider First-Level Appeals
   PO Box 13898
   Sacramento, CA 95853-4898

Denti-Cal will acknowledge the written complaint or grievance within 21 calendar days of receipt. The complaint or grievance will be reviewed by Denti-Cal Provider Services, and a report of the findings and reasons for the conclusions will be sent to the provider within 30 days of the receipt of the complaint or grievance. If review by Provider Services determines it necessary, the case may be referred to Denti-Cal Professional Review.

If the complaint or grievance is referred to Denti-Cal Professional Review, the provider will be notified that the referral has been made and a final determination may require up to 60 days from the original acknowledgement of the receipt of the complaint or grievance. Professional Review will make its evaluation and send findings and recommendations to the provider within 30 days of the date the case was referred to Professional Review.

The provider should keep copies of all documents related to the first-level appeal.

Under Title 22 regulations, a Denti-Cal provider who is dissatisfied with the first-level appeal decision may then use the judicial process to resolve the complaint. In compliance with Section 14104.5 of the Welfare and Institutions Code, the provider must "seek judicial remedy" no later than one year after receiving notice of the decision of the First Level Appeal.

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Health Insurance Portability and Accountability Act (HIPAA) and the National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers, as well as the adoption of standard unique identifiers for health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. NPPES collects identifying information on health care providers and assigns each a unique National Provider Identifier (NPI) number.

The NPI is a unique 10-digit number, used across the country to identify providers to health care partners, regardless of type of practice or location. All public and private health plans are required by HIPAA to receive/submit the NPI as the only provider identifier in all electronic transactions.

It is required for use in all HIPAA transactions:

- health care claims
- claim payment/remittance advice
- coordination of benefits
- eligibility inquiry/response
- claim status inquiry/response
- referrals
- enrollment

Information on how to apply for an NPI can be found here: https://nppes.cms.hhs.gov.

Registering NPIs

All NPIs (both billing and rendering providers) must be registered with Denti-Cal in order to ensure appropriate payment of claims in a timely manner. Providers may register their NPIs through one of three options:

1. Submitting a hardcopy registration form (DHCS 6218) by mail, or
2. Calling the Denti-Cal Telephone Service Center at (800) 423-0507, or
3. Register NPIs using the Denti-Cal Web Collection System on the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

Rendering providers who have not submitted a Social Security Number to Denti-Cal at the time of enrollment will not be able to register using the Denti-Cal Web site. Such providers will need to register using the Denti-Cal NPI Registration Form (DHCS 6218) found on the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

Freedom of Information Act (FOIA)-Disclosable Data

NPPES health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS has these data via the Internet. Data is available in two forms:

- A query-only database, known as the NPI registry.
- A downloadable file.

For more information on FOIA visit: http://www.cms.hhs.gov/aboutwebsite/04_FOIA.asp.

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Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is the computer-to-computer transfer of transactions and information. Providers are encouraged to submit claims electronically for improved productivity and cost efficiency.

EDI enrollment and other important EDI information can be obtained by:

- accessing the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=EDI, or:
- sending an e-mail to denti-caledi@delta.org, or:
- calling the Denti-Cal Telephone Service Center at (800) 423-0507, or
- calling (916) 853-7373 and asking for EDI Support

Enrollment requirements for EDI can be found in "Section 3: Enrollment Requirements" of this Handbook.

Providers using EDI for claims submissions are still required to provide radiographs and other attachments to Denti-Cal. They can be sent either by mail or digitally through a certified electronic attachment vendor.

Digitized Images

In conjunction with claims and TARs submitted electronically, Denti-Cal now accepts digitized radiographs and attachments submitted through electronic attachment vendors National Electronic Attachment, Inc. (NEA), National Information Services (NIS), and Tesia Clearinghouse, LLC.

Note: Providers must be enrolled in EDI to submit documents electronically prior to submitting digitized images. For more information see "Section 3: Enrollment Requirements" of this Handbook.

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Overview of TAR and Claim Processing

In administering the Denti-Cal Program, Denti-Cal's primary function is to process TARs and Claims submitted by providers for dental services performed for Medi-Cal recipients. It is the intent of Denti-Cal to process TARs and Claims as quickly and efficiently as possible. A description of the processing workflow is offered to promote a better understanding of the Denti-Cal automated claims processing system.

Document Control Number (DCN)

All incoming documents are received and sorted in the Denti-Cal mail room. TARs and Claims are separated from other incoming documents, including general correspondence, and assigned a Document Control Number (DCN).

The DCN is a unique number containing 11 digits in the following format:

14 059 1 000 01

The first five digits of the DCN represent the Julian date of receipt. In the example shown above, "14"designates the year, and "059" designates the fifty-ninth day of that year. The sixth digit, "1," identifies the type of document: 1 = TAR/Claim form. The remaining five digits of the DCN represent the sequential number assigned to the document. Thus, the document assigned the DCN shown in the example above would be the first TAR or Claim received by Denti-Cal on the fifty-ninth day of 2014 or February 28, 2014.

TARs and Claims plus any attachments are then scanned, batched, and forwarded to Data Entry, where pertinent data from the forms is entered into the automated claims processing system.

Edits and Audits

After data from the TAR or Claim is scanned into the system, the information is automatically edited for errors. Errors are highlighted on a display screen, and the data entry operator validates the information entered against the scanned image. When necessary corrections are made and the operator confirms that the information scanned is correct, the system prompts the operator as to the proper disposition of the TAR or Claim.

TAR/Claim Adjudication

Information on a TAR or Claim is audited via a series of manual and automated transactions to determine whether the services listed should be approved, modified or disallowed. If the claim data is determined to be satisfactory, the result is payment, with the issuance of an EOB and a check.

If the TAR data is determined to be satisfactory, the result is authorization of treatment, with the issuance of a NOA.

If the information submitted on the TAR or Claim is not sufficient, the document is held for further manual review until a resolution can be concluded. In some instances, more information may be required to make a determination. Denti-Cal will issue a Resubmission Turnaround Document (RTD) to request additional information from the provider.

Radiographs

Radiographs should be taken only for clinical reasons as determined by the beneficiary's dentist. Radiographs are part of the beneficiary's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

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Radiographs and photographs will not be returned.

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Prior Authorization

Prior authorization is required for some Denti-Cal benefits. For detailed information regarding procedures requiring prior authorization, please refer to "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Following is a list of Denti-Cal procedures requiring prior authorization:

Restorative

D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791

Endodontics

D3222, D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3410, D3421, D3425, D3426

Periodontics

D4210, D4211, D4260, D4261, D4341, D4342, D4999

Prosthodontics (Removable)

D5110, D5120, D5211, D5212, D5213, D5214, D5860, D5899 (non-emergency)

Maxillofacial Prosthetics

D5937, D5958, D5986, D5988, D5999 (non-emergency)

Implant Services

D6010, D6040, D6050, D6053, D6054, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6078, D6079, D6080, D6090, D6091, D6094, D6095, D6194, D6199

Fixed Prosthodontics

D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D6970, D6972, D6999

Oral & Maxillofacial Surgery

D7280, D7283, D7290, D7340, D7350, D7840, D7850, D7852, D7854, D7858, D7860, D7865, D7872, D7873, D7874, D7875, D7876, D7877, D7880, D7899 (non-emergency), D7940, D7941, D7943, D7944, D7945, D7950, D7951, D7955, D7991, D7995

Orthodontics

D8080, D8210, D8220, D8660, D8670, D8680, D8999 (non-emergency)

Adjunctive Services

D9220, D9221, D9241, D9242, D9950, D9952, D9999 (non-emergency)

Dental services provided to patients in hospitals, skilled nursing facilities, and intermediate care facilities are covered under the Denti-Cal Program only following prior authorization of each non-emergency and non-diagnostic dental service (Section 51307(f)(3), Title 22, California Code of Regulations). Emergency services may be performed on convalescent patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. However, the provider must submit clinical information with the claim describing the beneficiary's condition and the reason the emergency services were necessary.

The Denti-Cal Program, within the Department, and California Code of Regulations (CCR), Title 22, Section 51455, state that prior authorization may be required of any or all providers for any or all covered benefits of the program except those services specifically exempted by Section 51056(a) and (b). These prior authorization requirements do not change when the beneficiary has other dental coverage; the provider should submit for prior authorization and indicate the primary carrier. No verbal authorization will be granted by Denti-Cal. Denti-Cal reserves the right to require prior authorization in accordance with these guidelines.

Election of Prior Authorization

If a provider chooses to submit a TAR for services that do not normally require prior authorization, Denti-Cal may not review these procedures. However, these services may be reviewed if they are submitted as part of a total treatment plan. When a provider receives a NOA for procedures on a TAR that do not normally require prior authorization, the NOA is not a guarantee that these procedures have been approved. (Refer to "Section 7: Codes", Adjudication Reason Codes 355A, 355B, and 355C.)

If a provider elects to have any proposed treatment plan prior authorized, all provisions relating to prior authorization for all services listed apply.

Non-Transfer of Prior Authorization

Prior authorization is not transferable from one provider to another. If for some reason the provider who received authorization is unable to complete the service or the beneficiary wishes to go to another provider, another provider cannot perform the service until a new treatment plan is authorized under his/her own provider number.

To expedite processing of a TAR with a change of provider, submit a new TAR with an attached statement from the beneficiary indicating a change of provider.

Retroactive Prior Authorization

Title 22, Section 51003, State of California Code of Regulations (CCR) allows for the retroactive approval of prior authorization under the following conditions:

- When certification of eligibility was delayed by the county social services office;
- When beneficiary's other dental coverage denied payment of a claim for services;
- When the required service could not be delayed;
- When a beneficiary does not identify himself/herself to the provider as a Medi-Cal beneficiary through deliberate concealment or because of physical or mental incapacity to identify himself/herself. The provider must submit in writing that concealment occurred, and the submission of the TAR must be within 60 days of the date the provider certifies he/she was made aware of the beneficiary's eligibility.

Clinical Screening

During the processing of the TAR, Denti-Cal may decide to further evaluate the beneficiary and schedule a clinical screening appointment.

If this occurs, the dental office will receive a letter notifying them that a screening will take place and the beneficiary will be sent a screening notification appointment letter. Clinical Screening Dentists, acting as members of the program's Quality Assurance Committee, serve as impartial observers to examine patients and report their objective clinical findings. Denti-Cal utilizes these observations as additional information to help in making a final determination of medical necessity or the appropriateness and/or quality of care.

Screening protocol dictates that the Clinical Screening Dentist is not allowed to discuss their clinical observations with providers, patients, or any third party. In addition, providers or the beneficiary's representatives are not allowed to accompany the beneficiary to a screening. To ensure attendance, it is also recommended that providers fully discuss proposed treatment with their patients before a clinical screening appointment. Failure to do so may result in a potential delay or denial of treatment.

Billing and Payment Policies

Billing Beneficiaries

Providers may not submit a claim to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service (other than Share of Cost). Section 51002 of Title 22 of the California Code of Regulations specifically prohibits billing or collecting from Medi-Cal beneficiaries for services included in the Denti-Cal Program scope of benefits, except for those patients who have a fiscal liability to obtain and/or maintain eligibility requirements.

In addition, Title 42, Volume 3, of the Code of Federal Regulations, reads as follows:

> Section 447.15 Acceptance of State payment as payment in full.
>
> A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with Sec. 431.55(g) or Sec. 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

Finally, Welfare & Institutions Code reads:

> 14107.3 Any person who knowingly and willfully charges, solicits, accepts, or receives, in addition to any amount payable under this chapter, any gift, money, contribution, donation, or other consideration as a precondition to providing services or merchandise to a Medi-Cal beneficiary for any service or merchandise in the Medi-Cal's program under this chapter or Chapter 8 (commencing with Section 14200), except either:
>
> (1) To collect payments due under a contractual or legal entitlement pursuant to subdivision (b) of Section 14000; or
>
> (2) To bill a long-term care patient or representative for the amount of the patient's share of the cost; or
>
> (3) As provided under Section 14019.3, is punishable under a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not to exceed ten thousand dollars ($10,000), or both such imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment in the state prison.

This clause means that a provider may not bill both the beneficiary and the program for the same Denti-Cal procedure. If the provider submits a claim to Denti-Cal, he/she can't bill the beneficiary for the difference between Denti-Cal's Schedule of Maximum Allowances (SMA) and the provider's usual, customary, and reasonable (UCR) fee.

If Medi-Cal eligibility is verified, the provider may not treat the beneficiary as a private-pay beneficiary to avoid billing Denti-Cal, obtaining prior authorization (when necessary) or complying with any other program requirement. In addition, upon obtaining eligibility verification, the provider cannot bill the beneficiary for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or share of cost. Providers cannot bill beneficiaries for private insurance cost-sharing amounts such as deductibles, co-insurance or copayments.

This clause means that once a provider has checked a beneficiary's eligibility, or has submitted a claim or TAR for services, then that provider has agreed to accept that beneficiary as a Denti-Cal beneficiary and can't later decide to not accept the beneficiary for treatment to avoid pre-authorization requirement or having to accept Denti-Cal fees. The provider also agrees not to charge the beneficiary for all or part of any treatment that has been deemed by Denti-Cal to be a covered benefit.

A provider and beneficiary may enter into a private agreement under the following scenarios:

a. The provider and beneficiary have agreed to have specific dental treatment performed outside of the Denti-Cal program. The provider

must have not verified the beneficiary's eligibility or submitted any TAR or claim to Denti-Cal for the current phase of treatment.

Or:

b. The provider has submitted a specific procedure on a TAR or claim to Denti-Cal that was subsequently denied on the basis that it was either not a benefit under Denti-Cal's scope of benefits or it was denied because it did not meet the criteria or time/frequency limitations for the specific procedure. Procedures that have been denied for technical or administrative reasons, such as failure to respond to Resubmission Turnaround Documents (RTDs), inadequate radiograph submission, signatures, or that the procedure is included in a global procedure billed, cannot be billed to the beneficiary under any circumstances.

Providers should establish written contracts with beneficiaries before any non-reimbursed Denti-Cal treatment is rendered. They should also secure the proper Denti-Cal denial if applicable.

Providers cannot bill a Denti-Cal beneficiary for broken appointments (42 CFR 447.15 and SSA 1902 (a)(19).

When beneficiaries request copies of records and/or radiographs, providers can charge them a reasonable fee for duplication, but only when they have the same policy for their private patients.

Providers may only bill beneficiaries their UCR fees if the $1,800 limit per calendar year for beneficiary services (dental cap) has been met and nothing has been paid on a procedure.

Providers may not bill beneficiaries when the program has paid any amount on a specific procedure as the result of the beneficiary cap being met. This partial payment on a procedure must be considered payment in full.

Beneficiary Reimbursements

In accordance with Welfare and Institutions Code Section 14019.3, a Denti-Cal provider is required to reimburse a Denti-Cal beneficiary who paid for a medically necessary covered service rendered by the provider during any of the following three time periods: 1) the 90-day period prior to the month of application for Denti-Cal; 2) the period after an application is submitted but prior to the issuance of the beneficiary's Medi-Cal card; and 3) after issuance of the beneficiary's Medi-Cal card for excess co-payments (i.e., co-payments that should not have been charged to the beneficiary).

By law, a Denti-Cal provider must reimburse a beneficiary for a claim if the beneficiary provides proof of eligibility for the time period during which the medically necessary covered service was rendered (and for which the beneficiary paid). Evidence of the reimbursement paid by the provider to the beneficiary should be submitted to the Denti-Cal program as a claim with the appropriate documentation to indicate that Denti-Cal eligibility was recently disclosed. The Department will allow the provider a timeliness override in order to bill Denti-Cal for the repaid services. If the provider does not reimburse the beneficiary, the beneficiary may contact the Department, inform the Department of the provider's refusal to reimburse, and then submit a request for reimbursement directly to the Department. In this case, the Department will contact the provider and request that the provider reimburse the beneficiary. Should the provider refuse to cooperate, the Department will reimburse the beneficiary for valid claims and recoup the payment from the provider. Additional sanctions may be imposed on the provider such as those set forth in Welfare and Institutions Code Section 14019.3.

Not a Benefit/Global

Dental or medical health care services that are not covered by the Medi-Cal program are deemed "not a benefit."

"Global procedures" are those procedures that are performed in conjunction with, and as part of, another associated procedure. Global procedures are not separately payable from the associated procedure.

Dental Materials of Choice

The Denti-Cal Program wants all providers to understand the important distinction between a beneficiary's entitlement to a medically necessary covered dental service and your professional judgment of which dental material is used to perform the service.

In general, a Denti-Cal beneficiary is entitled to covered services that are medically necessary. The choice of dental material used to provide a specific service lies within the scope of the professional judgment of the dentist.

Providers may not bill beneficiaries for the difference between the Denti-Cal fee for covered benefits and the UCR fee.

Payment Policies

Denti-Cal will only pay for the lowest cost procedure that will correct the dental problem. For example, Denti-Cal cannot allow a porcelain crown when a restoration would correct the dental problem. A dental office cannot charge Denti-Cal more than it charges a private beneficiary for the services performed. The dental office should list its UCR fees when filling out the claim, TAR or NOA, not the SMA.

For tax purposes, Denti-Cal uses Form 1099 to report earnings to the Internal Revenue Service (IRS) for each billing provider who has received payment from Denti-Cal during the year. Federal law requires that Denti-Cal mail 1099 forms by January 31 of each year to reflect earnings from January 1 through December 31 of the previous year.

It is the provider's responsibility to make certain Denti-Cal has the correct billing provider name, address and Taxpayer Identification Number (TIN) or Social Security Number (SSN) that correspond exactly to the information the IRS has on file. If this information does not correspond exactly, Denti-Cal is required by law to apply a 28 percent withholding to all future payments made to the billing provider. To verify how tax information is registered with the IRS, please refer to the preprinted label on IRS Form 941, "Employer's Quarterly Federal Tax Return," or any other IRS-certified document. The provider may also contact the IRS to verify how a business name and TIN or SSN are recorded.

If a provider does not receive the 1099 form, or if the tax or earnings information is incorrect, please contact Denti-Cal at (800) 423-0507 for the appropriate procedures for reissuing a correct 1099 form.

Assistant Surgeons

Assistant surgeons should bill Denti-Cal using Procedure D6199/D7999 (as applicable) and may be paid 20% of the surgical fee paid to the primary surgeon (dentist or physician) provided the following is submitted with the claim:

- The operating report containing the name of the assistant surgeon;
- Proof of payment to the primary surgeon.

Surgical fees include major maxillofacial and orthognathic procedures, as well as trauma surgery, and include all associated extractions. All other procedures (anesthesia, radiographs, restorations, etc.) performed on the same date of service as the surgical procedure including bedside visits and hospital care are not considered in the determinations of the surgical fee and are not payable to assistant surgeons.

Providing and Billing for Anesthesia Services

Prior Authorization is required for general anesthesia (GA) and intravenous (IV) sedation. A TAR can only be requested from an enrolled Denti-Cal provider. The anesthesiologist may submit a TAR if they are enrolled as a billing provider. If an anesthesiologist is not a billing provider, the billing provider rendering the dental services may submit the TAR on behalf of the anesthesiologist rendering the anesthesia. Additionally, if an anesthesiologist is part of a group practice, the group practice may submit a TAR on behalf of anesthesiologist.

Note: Prior authorization is not required for a beneficiary who resides in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled.

The provider must submit a documentation indicated below to justify the medical necessity for anesthesia services.

If the provider provides clear medical record documentation of both number 1 and number 2 below, then the patient shall be considered for intravenous sedation or general anesthetic:

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.
2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for intravenous sedation or general anesthetic:

3. Use of effective communicative techniques and immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.
4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due a lack of psychological or emotional maturity that inhibits the ability to appropriately respond to commands in a dental setting.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

Prior authorization can be waived when Intravenous Sedation/General Anesthesia is medically necessary to treat an emergency medical condition. An "emergency medical condition" is defined in Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, Section 51056 (b).

Billing providers must ensure that all their rendering dental anesthesiologists and dentists providing general anesthesia and intravenous conscious sedation/analgesia are permitted or certified through the Dental Board of California prior to enrolling in the Denti-Cal program and prior to treating Medi-Cal patients (B&P Code 1646.1and 1647.19-20). Payments made to billing providers for services performed by their unenrolled rendering providers will be subject to payment recovery per Title 22, Section 51458.1 (a)(6).

The following is required to receive payment for administering general anesthesia or intravenous conscious sedation/analgesia:

- The rendering provider performing the general anesthesia must have a valid permit with the Dental Board of California and the permit number must be on file with Denti-Cal.
- The anesthesia record must be signed by the anesthesiologist performing the anesthesia procedure. The rendering provider name on the anesthesia record must coincide with the rendering provider number in field 33 on the claim for payment.

Tamper-Resistant Prescription Pads

In order for Denti-Cal outpatient drugs to be reimbursable by the federal government, all written, non-electronic prescriptions must be executed on tamper-resistant pads. The tamper-resistant prescription pad requirement applies to over-the-counter drugs, and impacts all dentists and other providers who prescribe outpatient drugs.

The Centers for Medicare and Medicaid Services (CMS) has issued guidance on this requirement that can be found on the Web site: www.cms.hhs.gov/center/intergovernmental.asp.

As outlined by CMS, a prescription pad must contain at least one of the following three characteristics and, by October 1, 2008, all three characteristics:

7. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
8. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or,
9. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The National Council for Prescription Drug Programs (NCPDP) has issued a letter providing additional information as to which tamper-resistant features fall within the three characteristics, a copy of which can be found on the Medi-Cal Web site: www.medi-cal.ca.gov.

The California-required tamper-resistant prescription pads for controlled drugs fully meet the federal compliance requirements. Prescribers are encouraged to use the current pads, and may order tamper-resistant prescription pads from security prescription printer companies.

Those companies preapproved by the California Department of Justice and Board of Pharmacy to produce tamper-resistant prescription pads are listed at the following Web site: www.oag.ca.gov/bne/security_printer_list.php. This directory provides an alphabetical listing of companies and is updated as new security prescription printers are approved. Providers will need their prescriber's state license number and a copy of their DEA Registration when they place their order. Other security prescription printer companies are available and may be used as needed. To comply with California statute, regardless of how a provider chooses to procure tamper-resistant prescription pads for all other written Medi-Cal prescriptions, providers must continue to procure tamper-resistant prescription pads for controlled drugs from the list of approved security prescription printer companies.

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Time Limitations for Billing

Time limitations for billing services provided under the Denti-Cal Program are governed by Section 14115 of the Welfare and Institutions Code. Claims received by Denti-Cal within:

- six calendar months after the end of the month in which the service was performed are considered for full payment (100 percent of the SMA)
- seven to nine months after the end of the month in which the service was performed will be considered for payment at 75 percent of the SMA amount.
- ten to twelve months after the end of the month in which the service was performed will be considered for payment at 50 percent of the SMA amount.

The time limitation for billing will be applied to each date of service.

Denti-Cal may receive and process late claims upon review of substantiating documentation that justifies the late submittal of a claim. The following is a list of reasons delayed submissions are acceptable when circumstances are beyond the control of the provider:

1. A beneficiary did not identify himself/herself to a provider as a Medi-Cal beneficiary at the time services were performed. The provider must submit the claim for payment within 60 days after the date certified by the provider that the beneficiary first did identify himself/herself as a Medi-Cal beneficiary. The date so certified on the claim must be no later than one year after the month in which services were performed.
2. The maximum time period for submission of a claim involving other coverage is one year from the date of service, to allow sufficient time for the provider to obtain proof of payment or non-liability of the other insurance carrier.
3. If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, Denti-Cal may extend the period of submission to one year from the date of service. Title 22, Section 51008, lists those specific circumstances which would be considered beyond the control of the provider and under which such an extension may be granted:
   - delay or error in the certification or determination of Medi-Cal eligibility by the State or county;
   - delay in delivering a completed removable appliance when a beneficiary does not return in a timely manner for delivery (Section 51470(b) states an undelivered, custom-made prosthesis must be retained for no less than one year after the date it was ordered, and is payable at 80% of the amount after the provider has attempted to deliver the prosthesis to the beneficiary);
   - damage to or destruction of provider's business office or records by natural disaster, including fire, flood, or earthquake; or circumstances involving such a disaster that have substantially interfered with the timely processing of bills;
   - delay of required authorization by Denti-Cal;
   - delay by Denti-Cal in supplying billing forms to the provider;
   - theft, sabotage, or other deliberate, willful acts by an employee;
   - other circumstances, clearly beyond the control of the provider that have been reported to the appropriate law enforcement or fire agency, where applicable;
   - special circumstances, such as court or fair hearing decisions.

Interim Payments

Interim payments are made to Denti-Cal providers for unpaid claims that have been delayed at least 30 days due to Denti-Cal or State errors, or for paid claims affected by retroactive changes.

A provider may contact Denti-Cal, either by telephone or in writing, to request interim payment. Denti-Cal will determine if a claim qualifies for interim payment. If it does not qualify, or if a determination cannot be made, Denti-Cal must notify the provider by telephone within 24 hours, followed by a written notice within two workdays. If Denti-Cal determines that a claim does qualify for interim payment, the findings are forwarded to the State for final approval or denial of the request.

When the State reaches a final decision, it will notify Denti-Cal.

Denti-Cal, in turn, will notify the provider. Once final approval of interim payment has been received from the State by Denti-Cal, the payment request is processed and a check is generated and sent to the provider.

Retroactive Reimbursement for Medi-Cal Beneficiaries for Out-of-Pocket Expenses

As a result of the Conlan v. Shewry court decision, a process has been implemented by which beneficiaries can obtain prompt reimbursement of their Denti-Cal covered, out-of-pocket expenses. For questions or instructions regarding this reimbursement, please phone the Conlan Help Desk at (916) 403-2007.

Denti-Cal Responsibilities

Denti-Cal responsibilities include the following:

- Verifying beneficiary Denti-Cal eligibility
- Evaluating supporting medical expense documentation provided by the beneficiary
- Reviewing rendered services for medical necessity
- Determining whether Denti-Cal payment was previously made
- Verifying that the provider reimbursed the beneficiary
- Maintaining documentation for each case

Provider Notification of Beneficiary Request for Reimbursement

If a beneficiary's request for reimbursement is validated by Denti-Cal, a letter of request for beneficiary reimbursement is sent to the provider. This letter must be submitted with the provider's claim for reimbursement.

Provider Responsibility

Upon receipt of a beneficiary reimbursement letter, providers are expected to reimburse beneficiaries for monies that the beneficiary paid to the provider at the time of service, then submit a claim to Denti-Cal. Claims will be denied if the beneficiary has not been reimbursed.

Claim Submission

Providers must submit claims to Denti-Cal within 60 days of the date on the letter as follows:

- Submit an original hard-copy claim solely for services mentioned in the beneficiary reimbursement letter
- Attach the beneficiary reimbursement letter
- Attach any additional required Denti-Cal documentation

The original claim, beneficiary reimbursement letter, and supporting documentation should be submitted to the following address:

Denti-Cal
Attn: Beneficiary Services
PO Box 526026
Sacramento, CA 95852-6026

No electronic claim submission is allowed. Denti-Cal determines medical necessity, therefore no TAR is required. The six-month billing limit will be waived for these claims.

Provider Reimbursement

Providers are reimbursed for medically necessary services according to the current SMA found in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

To be reimbursed, the provider must have been enrolled as a Denti-Cal provider on the date of service. Providers should contact Denti-Cal at (800) 423-0507 or online at http://www.denti-cal.ca.gov/ if any of the following conditions apply:

- Provider was not a Denti-Cal provider on the date of service but wants to enroll now
- Provider is a Denti-Cal provider now, but was not enrolled on the date of service and needs retroactive eligibility
- Provider was not a Denti-Cal provider on the date of service, but wants to temporarily enroll retroactively in Denti-Cal in order to bill for the Beneficiary Reimbursement Process claims

For more information on Provider Enrollment, please refer to "Section 3: Enrollment Requirements" of this Handbook.

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Medicare/Medi-Cal Crossover Claims

Medicare will pay for the following dental services: D0502, D5924, D5931, D5932, D5934, D5935, D5936, D5999, D7285, D7286, D7450, D7451, D7460, D7461, D7465, D7490, D7610, D7620, D7630, D7640, D7650, D7660, D7680, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7780, D7810, D7820, D7830, D7840, D7850, D7852, D7854, D7856, D7858, D7860, D7865, D7870, D7872, D7873, D7874, D7875, D7876, D7877, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7981, D7982, D7991, D7995, D7997.

Please note that the following codes listed above require prior authorization: D5999, D7850, D7852, D7854, D7858, D7860, D7865, D7872, D7873, D7874, D7875, D7876, D7877, D7940, D7941, D7943, D7944, D7945, D7950, D7955, D7991, D7995.

If a TAR/Claim is submitted for a Denti-Cal beneficiary and Field 31 contains any of the procedure codes listed above, the claim or TAR must be accompanied by official documentation which clearly shows proof of payment/denial by Medicare or states the beneficiary's ineligibility. Documentation of ineligibility may be:

1. An Explanation of Medicare Benefits (EOMB) stating "No Part B coverage";
2. An EOMB stating "Benefits are exhausted";
3. An official document verifying the beneficiary's alien status;
4. An EOMB or any official document from the Social Security Administration verifying beneficiary's ineligibility for Medicare.

Denti-Cal processes claims and TARs for Medicare covered dental services in accordance with the following Medicare/Medi-Cal crossover policies and procedures:

1. A provider must be enrolled with Medicare to bill Denti-Cal for Medicare/Medi-Cal crossover services.
2. Medicare must be billed for Medicare covered services prior to billing Denti-Cal. When billing Denti-Cal, attach the EOMB to the claim form.
3. Approved and paid Medicare dental services do not require prior authorization by Denti-Cal.
4. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a beneficiary has no direct bearing on the coverage or exclusion of any given dental procedure.

For information about Medicare enrollment and billing procedures, please visit the Noridian Healthcare Solutions web site:

https://med.noridianmedicare.com/web/jeb

When processing a claim with Medicare covered services, Denti-Cal reviews the EOMB submitted with the claim. The Medicare procedures listed on the EOMB are matched with the Denti-Cal procedures listed on the claim. Payment calculations are based on Medicare deductibles, coinsurance and Medi-Cal allowable amounts up to the SMA.

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Orthodontic Services Program

The provision of medically necessary orthodontic services is limited to Medi-Cal and California Children's Services (CCS) eligible individuals under 21 years of age by dentists qualified as orthodontists under the California Code of Regulations, Title 22, Section 51223(c). For additional information, see "Section 9: Special Programs" of this Handbook.

Dental Restorations for Children Under Age Four and for Developmentally Disabled Beneficiaries of Any Age

Senate Bill (SB) 1403 (Chapter 61, signed July 7, 2006), stipulates that "For any beneficiary who is under four years of age, or who, regardless of age, has a developmental disability, as defined in subdivision (a) of [Welfare and Institutions Code] Section 4512, radiographs or photographs that indicate decay on any tooth surface shall be considered sufficient documentation to establish the medical necessity for treatment provided."

Claims, NOAs, and CIFs with dates of service on or after January 1, 2007, and any TAR or reevaluation requiring review will only require one radiograph or photograph that demonstrates medical necessity to be submitted. When the radiograph or photograph demonstrates at least one decayed surface, all of the fillings and prefabricated crowns on that document will be allowed, unless the beneficiary's history indicates the tooth has been previously extracted, a recent filling/prefabricated crown, etc.

Providers who are replacing fillings or prefabricated crowns that they previously placed must submit a current radiograph or photograph of that tooth that demonstrates the need for replacement when the applicable time limitations have not been met.

- When no radiographs or photographs are submitted, or when the single radiograph or photograph that is submitted is not current or is non-diagnostic, all fillings and prefabricated crowns on that document will be denied/disallowed.
- When there is no decay evident in the single radiograph or photograph submitted, all restorations will be denied/disallowed.
- When a pulpotomy is requested in conjunction with a filling/prefabricated crown, and the filling/prefabricated crown is denied/disallowed, the pulpotomy will also be disallowed.

Children Under Age Four

The beneficiary must be under the age of four at the time the services were rendered or when the request for authorization was reviewed.

Developmentally Disabled (DD) Beneficiaries

Senate Bill (SB) 1403 (Chapter 61, signed July 7, 2006), amends Section 14132.88 of the Welfare and Institutions (W & I) Code in the following ways:

Once a provider has established the fact that their beneficiary is a client of a Regional Center/ Department of Developmental Services, he/ she must document that fact on the document by writing the following – "Registered Consumer of the Department of Developmental Services." No substitute language or documentation will suffice.

When requesting authorization/payment of prefabricated crowns on permanent teeth for DD patients, the requirement for arch films will be waived.

Hospital (Special) Cases

When dental services are provided in an acute care general hospital or a surgicenter, the provider must document the need for hospitalization, e.g., retardation, physical limitations, age, etc.

To request authorization to perform dental-related hospital services, providers need to submit a TAR with radiographs/photos and supporting documentation to Denti-Cal. Prior authorization is required only for the following services in a hospital setting: fixed partial dentures, removable prosthetics, and implants.

It is not necessary to request prior authorization for services that do not ordinarily require authorization from the Denti-Cal program, even if the services are

provided in an outpatient hospital setting. In all cases, an operating room report or hospital discharge summary must be submitted with the claim for payment.

Hospital Inpatient Dental Services (Overnight or Longer)

Inpatient dental services are defined as services provided to beneficiaries residing in hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and those who are homebound.

Dental services provided to patients in hospitals are covered under the Denti-Cal Program only following prior authorization of each non-emergency and non-diagnostic dental service (Section 51307(f)(3), Title 22, California Code of Regulations). Emergency services may be performed on hospital patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. However, the provider must submit clinical information with the claim describing the beneficiary's condition and the reason the emergency services were necessary.

Inpatient dental services (hospitals, SNFs, and ICFs) are covered only when provided on the signed order of the provider responsible for the care of the beneficiary. A claim for inpatient dental services must show verification that the services are to be rendered on the signed order of the admitting physician or dentist.

If a Denti-Cal provider needs to perform dental services within a hospital inpatient setting, the provision of the medical support services, e.g., Operating Room (OR) time, surgical nurse, anesthesiologist, or hospital bed, will depend on how the Denti-Cal beneficiary receives their Medi-Cal medical services. Denti-Cal beneficiaries may receive their medical services through a number of different entities:

- Medi-Cal Fee-For-Service (FFS)
- Geographic Managed Care (GMC)
- Medi-Cal Managed Care
- County Organized Health Systems (COHS)

Denti-Cal providers should refer to "Section 4: Treating Beneficiaries" of this Handbook for instructions on how to determine the entity providing a beneficiary's medical services.

Prior authorization is required for each non-emergency and non-diagnostic dental service provided to Denti-Cal beneficiaries in a hospital inpatient setting where the beneficiary's hospital stay exceeds 24 hours. This authorization must be submitted on the Medi-Cal Form 50-1 and sent directly to this address:

Department of Health Care Services
San Francisco Medi-Cal Field Office
P.O. Box 3704
San Francisco, CA 94119
(415) 904-9600

The Medi-Cal Form 50-1 should not be submitted to Denti-Cal as this will only delay the authorization for hospital admission.

For more information regarding the Medi-Cal TAR field offices, please review this document: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarfield_m00i00o01o03o04o06o07o08o11a02a04a05a06a07a08p00l00.doc

If the beneficiary requires emergency hospitalization, a "verbal" authorization is not available through the Medi-Cal field office. If the beneficiary is admitted as an emergency case, the provider may indicate in the Verbal Authorization Box on the Medi-Cal Form 50-1, "Consultant Not Available" (CNA). An alternative is to admit the beneficiary as an emergency case and submit the Medi-Cal Form 50-1 retroactively within ten working days to the Medi-Cal field office.

A claim for payment of dental services is submitted to Denti-Cal and must be accompanied by a statement documenting the need and reason the emergency service was performed. Include a copy of the operating room report.

Requesting Hospital Dental Services for Medi-Cal Beneficiaries Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans

The dentist must contact the beneficiary's medical plan to arrange for hospital or surgicenter admission and medical support services. All medical plans that provide services to Medi-Cal managed care

beneficiaries are contractually obligated to provide medical support services for dental treatment. If the Medi-Cal Field Office receives a Form Medi-Cal Form 50-1 for a Medi-Cal beneficiary who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

For more information about Denti-Cal inpatient and out-patient services, please review this document: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dentiio_i00o03o05.doc

Homebound Patients (Place of Service 2)

A physician's letter is required when requesting dental services for a beneficiary who cannot leave his/her private residence due to a medical condition. The physician's letter must be on his/her professional letterhead with the following information documented:

- The beneficiary's specific medical condition
- The reason the beneficiary cannot leave the private residence
- The length of time the beneficiary will be homebound

Emergency services may be performed on homebound patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. In addition to the submission requirements for each individual procedure, the provider must also submit documentation with the claim describing the beneficiary's condition and the reason the emergency services were necessary. A letter from the beneficiary's physician, as stated above, must also be submitted with the claim.

Skilled Nursing and Intermediate Care Facilities (Place of Service 4 or 5)

The California Department of Public Health defines a Skilled nursing facility and Intermediate care facility as the following:

- Skilled nursing facility (SNF) means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Refer to California Health & Safety Code, Section 1250 for more details.
- Intermediate care facility (ICF) means a health facility that provides inpatient care to ambulatory or non ambulatory patients who have a recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. Refer to California Health & Safety Code, Section 1250 for more details.

Providers may use the California Department of Public Health Web site to verify licensed facilities: http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx

All TARs and claims submitted for patients residing in SNFs or ICFs must include the following:

- place of service 04 or 05 (only) must be indicated regardless of where the dental services were or will be performed.
- facility name, phone number and address, regardless of where the dental services were or will be performed in Box 34 of the claim or TAR form.
- when treating residents outside of the facility, indicate the actual place of service in Box 34.

All procedures rendered on patients residing in an SNF or ICF require prior authorization with the exception of the following emergency and diagnostic services:

D0120, D0150, D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0330, D0340, D0350, D0502, D0999, D1110, D1120, D1206, D1208, D1555, D2940, D2970, D3221, D4910, D4920, D5410, D5411, D5421, D5422, D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660, D5850, D5851, D6092, D6093, D7285, D7286, D7510, D7511, D7521, D9110, D9120, D9210, D9220, D9221, D9241, D9242, D9410, D9430, D9440, D9910, D9930.~~D0120, D0150, D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0330, D3340, D0350, D0502, D1110, D1120, D1206, D1208, D1555, D2940, D2970, D3221, D4910, D4920, D5410, D5411, D5421, D5422, D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660,~~

~~D5850, D5851, D6092, D6093, D7511, D7521, D7285, D7286, D9110, D9120, D9210, D9410, D9430, D9440, D9910, D9930.~~

Emergency services may be performed on SNF and ICF patients without prior authorization for the alleviation of pain or treatment of an acute dental condition. In addition to the submission requirements for each individual procedure, the provider must also submit documentation with the claim describing the beneficiary's condition and the reason the emergency services were necessary.

In order to determine medical necessity and the beneficiary's adaptability and compliance with requested treatment, prior authorization requests may be evaluated by a Clinical Screening Dentist.

Note: Prior authorization will be waived for facility patients treated in a hospital or surgical center except for fixed partial dentures and removable prostheses and implants.

Hospital Care (Including Surgical Centers) (Place of Service 6 or 7)

In a hospital setting, prior authorization for treatment included in the scope of benefits is not required except for laboratory processed crowns, fixed partial dentures, and implants. When treatment is performed without prior authorization (on a procedure that would normally require prior authorization), requests for payment must be accompanied by radiographs, photographs, and any documentation to adequately demonstrate the medical necessity. Refer to the individual procedures for specific requirements and limitations. In addition, requests for payment must be accompanied by an operating room report that indicates the amount of time spent in the operating room suite.

Mobile Dental Treatment Vans (Place of Service 8)

Mobile dental treatment vans are considered, under Denti-Cal, to be an extension of the provider's office and are subject to all applicable requirements of the program.

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Section 3 - Enrollment Requirements

Provider Application and Disclosure Forms

To receive payment for dental services rendered to Medi-Cal beneficiaries, prospective providers must apply and be approved by Denti-Cal to participate in the Denti-Cal Program. When a provider is enrolled in the Denti-Cal program, Denti-Cal sends the provider a letter confirming the provider's enrollment effective date. Denti-Cal will not pay for services until the provider is actively enrolled in the Denti-Cal Program.

The Denti-Cal Program utilizes the same applications as those used by providers participating in the Medi-Cal Program. A prospective provider must use the most current version of these forms. To obtain a current application packet, contact Denti-Cal toll-free at (800) 423-0507 or visit the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=ApplicationForms. Failure to submit the appropriate form(s) and supporting documentation will delay the processing of an application and it will be returned as incomplete.

Applicants who are natural persons licensed or certificated under the Business and Professions Code or the Osteopathic or Chiropractic Initiative Acts to provide health care services, or who are professional corporations under subdivision (b) of Section 13401 of the Corporations Code, must enroll in the Medi-Cal Program as either individual providers or as rendering providers in a provider group. This is true even if the person or the professional corporation meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code (see W&I Code Section 14043.15(b)(1)).

W&I Code Section 14043.26(a)(1) requires a prospective provider not currently enrolled in the Medi-Cal Program or a provider applying for continued enrollment to submit a complete application package for enrollment, continued enrollment, or enrollment at a new location or a change in location.

An applicant or provider shall complete and submit the following applications/forms, as applicable:

- Medi-Cal Provider Group Application - DHCS 6203 (Rev. 2/08)
- Medi-Cal Provider Application - DHCS 6204 (Rev. 2/08)
- Medi-Cal Change of Location Form for Individual Physician or Individual Dentist Practices Relocating Within the Same County (DHCS 9096, Rev 1/11)
- Medi-Cal Disclosure Statement - DHCS 6207 (Rev. 02/15)
- Medi-Cal Provider Agreement - DHCS 6208 (Rev. 11/11)
- Medi-Cal Supplemental Changes - DHCS 6209 (Rev. 2/08)
- Medi-Cal Rendering Provider Application/Disclosure Statement/ Agreement for Physician/Allied/Dental Providers - DHCS 6216 (Rev. 2/15)
- Successor Liability with Joint and Several Liability Agreement - DHCS 6217 (Rev. 2/08)
- National Provider Identifier Registration – DHS 6218 (Rev. 2/08)

Denti-Cal does not accept application forms with a revision date prior to 02/08. The forms listed above with a revision date of 02/08 or later will be accepted.

Prospective providers must have received a National Provider Identifier (NPI) prior to applying to the Medi-Cal Dental Program. This unique identifier is required on all Medi-Cal applications.

Rendering Provider Enrollment Process

In accordance with the California Code of Regulations (CCR), Title 22, §51000.31(b), rendering providers must apply to the Denti-Cal Program by submitting a Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied Dental Providers (DHCS 6216, Rev. 2/15) form.

Rendering providers must be enrolled in the Denti-Cal program prior to rendering services to a Denti-Cal beneficiary. Denti-Cal will not pay for services until

the provider is actively enrolled in the Denti-Cal Program.

Enrolled rendering providers in good standing may join existing provider groups or practice at other locations without submitting additional applications for each location.

Applications may be obtained by contacting the Telephone Service Center at (800) 423-0507, or visit the Denti-Cal Application Forms section on the Denti-Cal Web site at: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=ApplicationForms.

Rendering providers must provide a National Provider Identifier (NPI). To obtain an NPI, you may go to the CMS Web site at: http://www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp.

Any modification to a rendering or billing provider's information (such as a change in address or ownership) requires Denti-Cal notification within 35 days of the change.

Pre-enrollment Inspection

Prior to enrollment in the Denti-Cal program, the applicant or provider may be subject to a pre-enrollment inspection or unannounced visit.

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Medi-Cal Provider Group Application (DHCS 6203, Rev. 2/08)

A new Medi-Cal Provider Group Application form is required to report any of the following enrollment actions:

- A dentist with one or more rendering dentists requesting to apply as a Denti-Cal Group provider
- A group dentist changing or requesting to add an additional business address
- A group dentist changing a Taxpayer ID number
- A group dentist changing ownership in the practice and/or reporting a cumulative change of 50% or more ownership or controlling interest

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 6203, as well as in California Code of Regulations (CCR), Title 22, Section 51000.31.

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL PROVIDER GROUP APPLICATION

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

  For Denti-Cal return completed forms to:

  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

Provider number (NPI or Denti-Cal provider number as applicable): _____

Date / /

Enrollment action requested **(check all that apply)**

- ❒ New provider
- ❒ Change of business address
- ❒ Additional business address
- ❒ New Taxpayer ID number
- ❒ Facility-Based Provider
- ❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
- ❒ *Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
- ❒ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- ❒ *Sale or transfer of assets (50 percent or more) (per Title 22, CCR, Section 51000.30)

For items above marked with * indicate effective date: ____/____/____.

- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)
- ❒ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

* **A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: _____/_____/_____.

Type of entity (check one)

- ❒ Sole proprietor
- ❒ Partnership
- ❒ Government entity
- ❒ Corporation: Corporate number: _____ State incorporated: _____
- ❒ Limited Liability Company (LLC): LLC number: _____ State registered/filed: _____
- ❒ Nonprofit Corporation Type of nonprofit: _____
- ❒ Other: _____

1. Legal provider group name (as listed with the IRS)

2. Business name, if different

Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date / /	3. Provider group telephone number ( )
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)		

4. Provider group business address (number, street)	City	County	State	Nine-digit ZIP code

a. If you are applying as a **facility-based provider**, complete this section:

This address is a licensed hospital/health facility. ❒ Yes ❒ No

If yes, check the option that applies:

❒ All services are provided at this one facility location **OR**

❒ Services are provided at more than one licensed health facility

(Attach a list of all business addresses where services are provided).

5. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
6. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

For a change of business address, enter location moving from:

7. Previous business address (number, street)	City	State	Nine-digit ZIP code

8. Taxpayer Identification Number (TIN) or social security number (Attach a legible copy of the IRS form)	9. Medicare/Other NPI (see instructions)	10. Seller's Permit number (attach a legible copy)

11. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code
12. Type of provider group	13. If physician(s) or dentist(s), list specialty(ies)	

DHCS 6203 (rev. 2/08)

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Sample

Medi-Cal Provider Application (DHCS 6204, Rev. 2/08)

A new Medi-Cal Provider Application form is required to report any of the following enrollment actions:

- A sole-proprietor dentist changing or adding an additional business address
- A sole-proprietor dentist changing his/her Taxpayer ID number
- A sole-proprietor dentist changing ownership in the practice and/or reporting a cumulative change of 50% or more ownership or controlling interest

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 6204, as well as in California Code of Regulations (CCR), Title 22, Section 51000.30.

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL PROVIDER APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

  For Denti-Cal return completed forms to:

  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507
- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you***

FOR STATE USE ONLY

Provider number (NPI or Denti-Cal number as applicable): _____

Date / /

Enrollment action requested **(check all that apply)**

- ❒ New provider
- ❒ Change of business address
- ❒ Additional business address
- ❒ New Taxpayer ID number
- ❒ Facility-Based Provider
- ❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
- ❒ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- ❒ *Sale of assets 50 percent or more, per Title 22, CCR, Section 51000.30)

For items above marked with * indicate effective date: ____/____/_____.

- ❒ Continued Enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)
- ❒ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

***A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: ____/____/_____.

Type of entity (check one)

- ❒ Sole proprietor
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Partnership (attach legible copy of agreement)
- ❒ Limited liability company (LLC):
  LLC number: _____
  State registered/filed: _____
- ❒ Government entity
- ❒ Nonprofit Corporation
  Type of nonprofit: _____
- ❒ Other: _____

Sample

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement/Permit number

Effective date / /

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street) | City | County | State | Nine-digit ZIP code

a. If you are applying as a **facility-based provider**, complete this section:

This address is a licensed hospital/health facility. ❒ Yes ❒ No

If yes, check the option that applies:

- ❒ All services are provided at this one facility location **OR**
- ❒ Services are provided at more than one licensed health facility

(Attach a list of all business addresses where services are provided).

5. Pay-to address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

For a change of business address, enter location moving from:

7. Previous business address (number, street) | City | State | Nine-digit ZIP code

8. License number (attach legible copy) | License effective date / / | License expiration date / / | 9. Provider type | 10. Medicare/Other NPI (see instructions)

11. Primary Taxonomy Code | Taxonomy Code | Taxonomy Code

12. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form)

13. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 5.)

– –

DHCS 6204 (rev. 2/08)

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Medi-Cal Change of Location Form for Individual Physician or Individual Dentist Practices Relocating Within the Same County (DHCS 9096, Rev 1/11)

A new Medi-Cal Change of Location form for Individual Physician or Individual Dentist Practices Relocating Within the Same County is available for those who meet the following criteria:

- The dental provider must meet the definition of an "individual dentist practice" as defined in W&I Code, Section 14043.1(l)(1).
- The dental provider must be changing the location of his or her individual dental practice within the same county.
- The information submitted by the dental provider in his or her last approved Medi-Cal application package, including their last Medi-Cal Disclosure Statement, remains true, accurate and complete to the best of the dental provider's knowledge and belief.

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 9096.

Sample Medi-Cal Change of Location Form for Individual Physician or Individual Dentist Practices Relocating Within the Same County (DHCS 9096, Rev 1/11)

State of California – Health and Human Services Agency

Department of Health Care Services

MEDI-CAL CHANGE OF LOCATION FORM FOR INDIVIDUAL **PHYSICIAN OR INDIVIDUAL DENTIST PRACTICES RELOCATING WITHIN THE SAME COUNTY**

FOR STATE USE ONLY

Important:

- Read all instructions before completing the form.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

- PHYSICIANS send completed form to:
  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997412
  Sacramento, CA 95899-7412
  (916) 323-1945
- DENTISTS send completed form to:
  Medi-Cal Dental Program **(Denti-Cal)**
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

Check each box below. Unless both of the statements apply to you, you are not eligible to use this change of location form and must instead submit a complete application package.

☐ I attest that I am an **individual dentist practice** as defined in Welfare and Institutions Code, Section 14043.1(l)(1) ***or*** I am an **individual physician practice** as defined in Welfare and Institutions Code, Section 14043.1(l)(2), ***and*** I am relocating within the same county.

☐ I attest that, with the exception of the change in location I am reporting with this form, the information in my last Medi-Cal application package, including the last Medi-Cal Disclosure Statement, submitted to and approved by the Department of Health Care Services remains true, accurate, and complete to the best of my knowledge and belief.

Date:

Sample

1. Legal name of applicant or provider (as listed with the IRS)	2. Provider number (NPI) (attach copy of CMS/NPPES confirmation)			
3. Business name, if different	4. Business Telephone Number ( )			
5. **New** business address (address number, street, suite number)	City	County	State	Nine-digit ZIP code
6. Pay-to address (post office box number or address number, street and suite number, as applicable)	City		State	Nine-digit ZIP code
7. Mailing address (post office box number or address number, street and suite number, as applicable)	City		State	Nine-digit ZIP code
8. Local business license/permit numbers (attach copy)	9. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach copy)	10. State Laboratory License/Registration Number (attach copy)		

Enter location you are moving from below:

11. **Previous** business address (number, street)	City	County	State	Nine-digit ZIP code

12. Proof of comprehensive liability insurance

Name of insurance company (**attach copy of the certificate of comprehensive liability insurance to this form)**

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
Insurance agent's name (first)	(middle)	(last) (Jr., Sr., etc.)
Telephone number ( )	Fax number ( )	E-mail address

13. Applicant Signature and Identification Information

Printed legal name of applicant (last) (first) (middle)	14. Dental/ Medical license number (attach copy)
Original signature of applicant	15. Drivers license number (attach copy)

Executed at: _____ (City) _____ (State) on _____ (Date)

Privacy Statement (Civil Code Section 1798 et seq.)

All information requested on this form is mandatory. This information is required by the Department of Health Care Services, Provider Enrollment, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945, or Denti-Cal at (800) 423-0507.

DHCS 9096 (rev 01/11)

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Medi-Cal Disclosure Statement (DHCS 6207, Rev. 2/15)

A new Medi-Cal Disclosure Statement is required when either the Medi-Cal Provider Application (DHCS 6204) or Medi-Cal Provider Group Application (DHCS 6203) are submitted.

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 6207, as well as in California Code of Regulations (CCR), Title 22, Section 51000.30.

Sample Medi-Cal Disclosure Statement (DHCS 6207, Rev. 2/15)

State of California—Health and Human Services Agency | Department of Health Care Services

MEDI-CAL DISCLOSURE STATEMENT

Do not leave any questions, boxes, lines, etc., blank. Check or enter N/A if not applicable to you.

I. APPLICANT/PROVIDER INFORMATION

A. Legal name of applicant/provider as reported to the IRS

B. Legal name of applicant/provider as it appears on professional license *IF NOT APPLICABLE, CHECK THE BOX* ☐ **N/A**

C. Existing provider numbers (NPI or Denti-Cal provider number as applicable) used at the address indicated in Item G below. ☐ **N/A**

D. If applying as a rendering provider to a provider group, check here ☐ and proceed to Part I. (marked with ***asterisk** below)

E. Fictitious business name ☐ **N/A**

F. "Doing Business As" name ☐ **N/A**

G. Address where services are rendered or provided (number, street) (City) (State) (Nine-digit ZIP code)

1. Does applicant/provider lease this location? ☐ Yes ☐ No
2. If YES, complete the following information regarding the Lessor and **enclose a copy of the current signed Lease Agreement**, including any sublease agreements entered into by the applicant provider at the business address on the Application.
   a. Lessor name
   b. Lessor address (number, street) (City) (State) (Nine-digit ZIP code)
   c. Lessor telephone number | d. Term of lease | e. Amount of lease
3. If no, does applicant/provider own this location? ☐ Yes ☐ No
4. If applicant/provider does not lease or own this location, explain below:

H. Type of Entity *(must check one)*:

☐ General Partnership *(Enclose Partnership Agreement)*
☐ Limited Partnership *(Enclose Partnership Agreement)*
☐ Limited Liability Partnership *(Enclose Partnership Agreement)*
☐ Sole Proprietor (Unincorporated)
☐ Limited Liability Company: State of formation: _____
☐ Governmental
☐ Corporation *(Enclose Articles of Incorporation and Statement of Information)* Corporate number: State incorporated: _____
☐ Nonprofit:
Check one: ☐ Corporation ☐ Unincorporated Association
Check one: ☐ Charitable ☐ Religious
☐ Other *(specify)*: _____

*I. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ **N/A**

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$		/ /	/ /
$		/ /	/ /

Do not leave any questions, boxes, lines, etc., blank.

DHCS 6207 (rev. 2/15) Page 1 of 15

Sample

Medi-Cal Provider Agreement (DHCS 6208, Rev. 11/11)

A new Medi-Cal Provider Agreement is required when either the Medi-Cal Provider Application (DHCS 6204) or Medi-Cal Provider Group Application (DHCS 6203) are submitted.

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 6208, as well as in California Code of Regulations (CCR), Title 22, Section 51000.30.

Sample Medi-Cal Provider Agreement (DHCS 6208, Rev. 11/11)

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*

FOR STATE USE ONLY

Do not use* staples *on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date

Legal name of applicant or provider (hereinafter jointly referred to as "Provider")	Business name (if different than legal name)		
Provider number (NPI or Denti-Cal provider number as applicable)		Business Telephone Number ( )	
Business address (number, street)	City	State	Nine-digit ZIP code
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Previous business address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Taxpayer Identification Number**			

Sample

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER", AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 26(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status, DHCS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section 14043.27(c).

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

* Every applicant and provider must execute this Provider Agreement, except physicians, who must execute the "Medi-Cal Physician Application/Agreement," DHCS 6210.

** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

DHCS 6208 (rev. 11/11)

Page 1 of 8

Medi-Cal Supplemental Changes (DHCS 6209, Rev. 2/08)

A Medi-Cal Supplemental Changes application is required to report any of the following actions within 35 days of the date of the change:

1. To add a:
   - Business activity
   - Doing-Business-As (DBA) name
   - License, permit, certification, etc.
   - Medi-Cal Supplemental Changes
   - Specialty code
2. To delete a:
   - Specialty code
3. To change:
   - A pay-to or mailing address and/or phone number
   - A person with ownership or control interest less than 50%
   - DBA name
   - Other information, e.g., legal name change (marriage, etc.)
4. Miscellaneous:
   - Issuance of new Provider Identification Number (PIN)

Further instructions are included on the DHCS 6209, and California Code of Regulations (CCR), Title 22, Section 51000.40.

Sample Medi-Cal Supplemental Changes (DHCS 6209, Rev. 2/08)

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL SUPPLEMENTAL CHANGES

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:
  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945
  For Denti-Cal return completed forms to:
  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507
- ***This is not the correct form for reporting a change in business address.***

FOR STATE USE ONLY

Legal provider name (as listed with the IRS)	Provider Number (NPI or Denti-Cal provider number as applicable)	Date / /

PROVIDER TYPE (check one)

- ❒ Dentist
- ❒ DME
- ❒ Laboratory
- ❒ Orthotic and prosthetic
- ❒ Pharmacy
- ❒ Physician
- ❒ Provider group
- ❒ Registered Dental Hygienist Alternative Practice
- ❒ Transportation
- ❒ Other provider type (please describe) _____

ACTION REQUESTED (check all that apply)

Add:

- ❒ Business activity
- ❒ Clinical Laboratory Improvement Amendment (CLIA)
- ❒ Doing-Business-As (DBA) name
- ❒ Licenses, permits, certificates, etc.
- ❒ Medical transportation vehicle, driver or pilot
- ❒ Seller's Permit
- ❒ Medicare/Other NPI
- ❒ Specialty code
- ❒ Taxonomy Code

Delete:

- ❒ Clinical Laboratory Improvement Amendment (CLIA)
- ❒ Medical transportation vehicle, driver, or pilot
- ❒ Specialty code

Change:

- ❒ NPI assigned to one or more locations--see page 10.

Change (continued):

- ❒ Address and/or phone (pay-to or mailing only)
  List any provider numbers the change is associated with:
  _____
- ❒ Medical transportation vehicle, driver, pilot or geographic area served
- ❒ Persons with ownership or control interest less than 50 percent
- ❒ Pharmacist-in-charge
- ❒ Managing employee
- ❒ Hours of operation
- ❒ Business activities
- ❒ Doing-Business As (DBA) name
- ❒ Other information previously submitted in an application package

Miscellaneous:

PIN (Provider Identification Number)

- ❒ Issuance (new PIN)
- ❒ Confirmation (existing PIN)
- ❒ Deactivate provider number _____
- ❒ Deactivate provider type/location (attach letter specifying change)

Sample

Complete only the boxes specific to the action requested. Complete boxes 35–40. Complete box 41, if applicable.

GENERAL INFORMATION

1. Business name, if different		2. Business telephone number ( )
Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date / /
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit, if applicable.)	

3. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
4. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

5.a. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	5.b. State Laboratory License/Registration number (attach a legible copy)	6. Medicare/Other NPI/Medicare Billing Number (see instructions)
7. Seller's Permit number (attach a legible copy)	8. Any local business license, permit or certificate numbers (attach a legible copy)	9.a. Specialty code(s), if applicable Add: _____ Delete: _____

DHCS 6209 (rev. 2/08)

Page 5 of 10

Medi-Cal Rendering Provider Application/Disclosure Statement/ Agreement for Physician/Allied Dental Providers (DHCS 6216, Rev. 2/15)

A new Medi-Cal Rendering Provider Application is required when adding an (unenrolled) Rendering Provider to the Denti-Cal Program.

All modifications pertaining to information previously submitted on the application must be submitted in writing to Denti-Cal within 35 days of the date of change.

Further instructions are included on the DHCS 6216, as well as in California Code of Regulations (CCR), Title 22, Section 51000.30.

Sample Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied Dental Providers (DHCS 6216, Rev. 2/15)

State of California—Health and Human Services Agency | Department of Health Care Services

MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

FOR STATE USE ONLY

Important:

- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:
  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997412
  Sacramento, CA 95899-7412
  (916) 323-1945

  For Denti-Cal return completed forms to:
  Department of Health Care Services
  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

☐ Preferred provider status requested pursuant to Welfare and Institutions Code Section 14043.26(d). All qualifying documentation and cover letter attached.

Do not use staples on this form or on any attachments. Do not use correction fluid or tape.
Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check[✓] all that apply)	National Provider Identifier (NPI)	Date
☐ New rendering physician/allied/dental provider		/ /

Provider Type (check one)

☐ Chiropractor ☐ Physician
☐ Audiologist ☐ Dentist ☐ Podiatrist ☐ Registered Dental Hygienist Alternative Practice
☐ Certified Nurse Midwife ☐ Optometrist ☐ Prosthetist ☐ Other: _____
☐ Certified Registered Nurse Anesthetist ☐ Orthotist ☐ Psychologist

1. Legal name of applicant	2. Date of birth	3. Gender
	/ /	

4. Residence address (number, street)	City	State	Nine-digit ZIP code

5. Mailing address (number, street)	City	State	Nine-digit ZIP code

6. Social security number (required)	7. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

8. Professional license/certificate/permit number (attach legible copy)	License/certificate/permit effective date	License/certificate/permit expiration date	List specialty(ies)—Physicians and dentists only	Yes	No
	/ /	/ /	Board-certified	☐	☐
			Board-eligible	☐	☐

9. Business address (office/hospital) (number, street)	City	County	State	Nine-digit ZIP code

10. Business telephone number	11. Contact person's name	12. Contact person's telephone number	13. Contact person's e-mail address
( )		( )	

14. Provider number (NPI or Denti-Cal Provider Number as applicable) of group being joined

15. **Proof of Professional Liability Insurance-Applicant must attach a copy of their certificate of (malpractice) insurance to this application.**

Name of Insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration Date of policy (mm/dd/yyyy)
	/ /	/ /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

DISCLOSURE INFORMATION

Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): _____
2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of final judgment (mm/dd/yyyy): _____
3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): _____

DHCS 6216 (rev. 2/15) Page 3 of 5

Sample

Successor Liability with Joint and Several Liability Agreement (DHCS 6217, Rev. 2/08)

A Successor Liability form is required to transfer liability in the result of a sale of practice.

Providers are reminded to also complete and submit:

- either the Medi-Cal Provider Group Application (DHCS 6203) or Medi-Cal Provider Application (DHCS 6204)
- the Medi-Cal Disclosure Statement (DHCS 6207)
- Medi-Cal Provider Agreement (DHCS 6208)

Further instructions are included on the DHCS 6217.

Sample Successor Liability with Joint and Several Liability Agreement (DHCS 6217, Rev. 2/08)

State of California–Health and Human Services Agency | Department of Health Care Services

SUCCESSOR LIABILITY WITH JOINT AND SEVERAL LIABILITY AGREEMENT

This section is to be signed and dated by provider transferor and transferee applicant:

_____ and _____ acknowledge that
(legal name of provider transferor on file with IRS) (legal name of transferee applicant on file with IRS)

the Medi-Cal Provider Agreement between the provider transferor and the Department of Health Care Services (DHCS) for the business operations at _____ is being assigned to the transferee applicant
(street address, city and nine-digit zip code of location being transferred)

effective _____/ /_____.
(effective date of transfer)

The provider transferor and transferee applicant acknowledge and agree that they both will be jointly and severally liable for all debts arising from the Medi-Cal Provider Agreement applicable to the location indicated below, from the date of this agreement until the transferee applicant's application is either approved or denied. Both transferor and transferee agree not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Both transferor and transferee agree that submission of an NPI to DHCS as part of an application to use that NPI for billing services constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Both transferor and transferee agree that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, Title 22, Section 51000.40.

FOR PROVIDER TRANSFEROR

Signed this _____ day of _____, _____
(day of month) (month) (year)

in _____, California.
(name of county where signed)

_____ _____/ /_____
(signature of provider transferor) (date)

_____ _____
(current NPI or Denti-Cal provider number of provider transferor) ("Fictitious Business" name of provider transferor, if applicable)

FOR TRANSFEREE APPLICANT

Signed this _____ day of _____, _____
(day of month) (month) (year)

in _____, California.
(name of county where signed)

_____ _____/ /_____
(signature of transferee applicant) (date)

_____ _____
(current NPI or Denti-Cal provider number of transferee applicant, if applicable) ("Fictitious Business" name of transferee applicant, if applicable)

I_____, declare under penalty of perjury under the laws of
(name of transferee applicant)

the State of California that I meet all of the requirements to be a Medi-Cal provider.

Executed at _____, _____, on _____/ /_____.
(city) (state) (date)

Notary Public

Notarization is required. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

This letter should be postmarked no later than five (5) days after the occurrence of the circumstance listed in California Code of Regulations (CCR), Title 22, Section 51000.30(b). The transferee applicant must submit a complete application package to be received by the Department within 35 days of the occurrence of a circumstance listed in (b)(1), (b)(2), (b)(6), or (b)(7). This is required per CCR, Title 22, Section 51000.30(b).

DHCS 6217 (Rev. 2/08)

Sample

National Provider Identifier Registration Form (DHS 6218, Rev. 2/08)

Billing and rendering providers enrolled in the Denti-Cal program prior to 5/23/07 must register their NPI(s) using either the following:

1. NPI Registration Form (DHCS 6218)
2. Denti-Cal NPI Collection System

Providers may request an NPI Registration Form by calling the Denti-Cal Telephone Service Center at (800) 423-0507 or by accessing the NPI Registration Form (DHCS 6218) on the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSINPIInfo.jsp?fname=NPIMain.

The Denti-Cal NPI Collection System is found on the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/NPIWebCollection.jsp?fname=NPIWebCollection.

Sample National Provider Identifier Registration Form (DHS 6218, Rev. 2/08)

STATE OF CALIFORNIA--HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

National Provider Identifier Registration Form

This form is being used to register your National Provider Identifier (NPI) with the California Department of Health Care Services Provider Enrollment Division (PED), Medi-Cal Dental Program (Denti-Cal), and Child Health and Disability Prevention Program (CHDP). All areas with an asterisk (*) are required. If you have any questions or need assistance with this form, please call the applicable NPI Helpdesk:

Medi-Cal – 1-800-541-5555 Denti-Cal -- 1-800-423-0507

NOTE: A separate NPI registration form is required for each existing Provider number.

*Medi-Cal, Denti-Cal, or CHDP Provider Number	*Provider Name	*NPI (attach a copy of the CMS/NPPES NPI confirmation letter to this form)

***PLEASE PROVIDE one of the following for Medi-Cal, Denti-Cal or CHDP:**

Provider Identification Number (PIN)	OR	Last 4 digits of Taxpayer Identification Number (TIN)	OR	Last 4 digits of Social Security Number (SSN)
PIN	Or	TIN	Or	SSN

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the information may result in your request being delayed or not be processed.

PROVIDER TAXONOMY CODE INFORMATION – Please enter each Taxonomy Code you provided in the original application to CMS/NPPES to obtain this NPI. Enter any additional Taxonomy Codes on the reverse side of this form.

Primary Taxonomy Code	Taxonomy Code	Taxonomy Code

NON-PHYSICIAN MEDICAL PRACTITIONER (NMP) NPI INFORMATION – Please enter the License Number and corresponding NPI for each NMP you provided in the original application to CMS/NNPES, if applicable. Enter any additional NMP License Numbers and NPI on the reverse side of this form.

NMP License Number	NMP NPI	NMP License Number	NMP NPI

Some Medi-Cal, Denti-Cal and CHDP provider agreements will need to be updated with this NPI information. Registration of the NPI will automatically update all agreements you may currently have on file. A complete list of these forms is on the reverse side of this form.

CONTACT INFORMATION FOR FOLLOW-UP – Please Print

*First Name	*Last Name

*Contact Phone Number	*Mailing Address for confirmation of processed NPI (Street, City, State, Zip)
( )	

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document and in the attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the provider.

*Print Name and Title of Authorized Representative or Provider

* Authorized Representative or Provider Signature	*Date

Return completed form to:

☐ **Medi-Cal/CHDP**
California Department of Health Care Services
PRO - NPI Help Desk
Medi-Cal Fiscal Intermediary
PO Box 13811
Sacramento, CA 95853-9946

☐ **Denti-Cal**
California Department of Health Care Services
Medi-Cal Dental Program
Provider Enrollment
PO Box 15609
Sacramento, CA 95852-0609

Agreement Update Information on reverse side.

DHCS 6218 (Rev. 02/08)

Page 1 of 2

Sample

Provisional Provider Status

The Welfare and Institutions Code (W & I) states:

Section 14043.26 - New providers will be enrolled as "provisional providers." These providers shall be subject to the terms of provisional provider status for a period of 12 months from the date of enrollment. After successful completion of the 12-month provisional period, the provider's status will be changed to reflect regular, active status.

All applications must be processed within 180 days and, upon approval, are granted provisional provider status for 12 months. If the provider is not notified after 180 days, provisional provider status will automatically be invoked.

Section 14043.28 - Providers who are subsequently denied enrollment will not be eligible to reapply for a period of three (3) years.

Section 14123.25 - Providers will be notified of improper billing practices via deficiency notices. Subsequent notices to the same providers may result in civil penalties being imposed by the Department.

Section 14172.5 - The Department shall pursue liquidation of overpayment 60 days after issuance of the first statement of accountability or demand for repayment, regardless of the status of the provider's appeal.

Preferred Provisional Provider Status

The Welfare and Institutions (W & I) Code section 14043.26(d) allows providers who meet the criteria identified in that section to be considered within 60 days for enrollment in the Medi-Cal program as preferred provisional providers.

Based upon the authority granted to the director of the Department of Health Care Services (DHCS) in W & I Code section 14043.75(b), the director has established the following procedures that must be followed for a provider to request enrollment in the Medi-Cal Dental program as a preferred provisional provider. These procedures implement W & I Code section 14043.26(d) as it relates to dental providers and have the full force and effect of law pursuant to W & I Code section 14043.75(b). These procedures are effective for all application packages received on or after December 27, 2012.

If the applicant does not meet the criteria for a preferred provisional provider, or the application package submitted fails to meet the requirements set forth, the applicant shall be notified within 60 days, and the submitted application package shall be processed under W & I Code section 14043.26 within 180 days from the date of the notice to the applicant or provider that s/he does not qualify as a preferred provider.

If a provider has already submitted an application to Denti-Cal for enrollment and they would like to request to be considered for a preferred provisional provider, they must meet all the criteria in item two below and submit all documentation listed in item two that was not already included in application package submitted along with a Cover Letter for Preferred Provisional Provider Enrollment as directed in item three below.

If the Medi-Cal Dental Program finds that a provider falsely certified that they meet the criteria to be a preferred provisional provider, the Medi-Cal Dental Program will recoup all payments for claims from Denti-Cal to provider.

Procedures for Enrollment as a Preferred Provisional Provider

An applicant or provider requesting consideration for enrollment as a preferred provisional provider must do all of the following:

1. Submit an application package that includes the:
   - Medi-Cal Provider Group Application (DHCS 6203, Rev. 2/08) or the Medi-Cal Provider Application (DHCS 6204, Rev. 2/08)
   - Medi-Cal Disclosure Statement (DHCS 6207, Rev. 2/15)
   - Sample Medi-Cal Provider Agreement (DHCS 6208, Rev. 11/11)

   The words "*Preferred Provisional Provider*" must be clearly written by the provider in bold print at the top of the first page of the Medi-Cal Provider Group Application or the Medi-Cal Provider Application. Failure to disclose required information or the disclosure of false information in the

application package requesting enrollment as a preferred provider, its attachments or in the *Cover Letter for Preferred Provisional Provider Enrollment* or its required statement, will result in denial or termination of the provisional provider status, and may result in further legal action.

2. Meet all of the following criteria and submit the listed documentation at the time of submission of the application package to the department:
3. Hold a current license as a dentist issued by the Dental Board of California, which has not been revoked, whether stayed or not, currently suspended, on probation, or subjected to other limitation. To meet this criterion, the applicant must include a copy of his/her dental license.
4. Submit documentation showing the dental provider is credentialed by a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975. Documentation may come in various forms including, but not limited to, a letter by the Knox-Keene licensed plan notifying the provider that they have successfully enrolled in the Knox-Keene licensed plan, the provider's most recent beneficiary roster from the Knox-Keene licensed plan without PHI, or proof of payment by a Knox-Keene licensed plan.
5. Have never had revoked and/or suspended privileges through the California Medicaid program Medi-Cal Dental.
6. Have no adverse entries in the Healthcare Integrity and Protection Data Bank/National Practitioner Data Bank (HIPDB/NPDB). To meet this criterion, the applicant must submit documentation from HIPDB/NPDB verifying that the database has no adverse entries regarding the applicant.
7. Include in the application package a Cover Letter for Preferred Provisional Provider Enrollment in which the applicant declares under penalty of perjury under the laws of the state of California that s/he meets all the criteria of a preferred provisional provider, has no adverse entries in the HIPDB/NPDB and holds a current license as a dentist through the Dental Board of California, which has not been revoked, whether stayed or not, suspended, placed on probation, or subjected to other limitation. The provider shall identify the place in California where the statement is made and include the date and signature of the applicant.

Tax Identification Number

Verify Your Tax Identification Number (TIN)

The Denti-Cal Program reports annually to the Internal Revenue Service (IRS) the amount paid to each enrolled billing provider. The Business Name and TIN must match exactly with the name and TIN on file with the IRS. TINs may be either a Social Security Number (SSN) or an employer identification number (EIN), which are printed on the front of the check and on the Explanation of Benefits (EOB). Please verify that the Business Name and TIN on the next check/EOB are correct. If the Business Name and TIN do not match, the IRS requires Denti-Cal to withhold 28% of future payments.

Providers do not need to notify Denti-Cal if the Business Name and/or TIN appearing on the Denti-Cal check/EOB are correct.

Updating Your Tax Identification Number

Updating your TIN is necessary only when:

- The Business Name and/or TIN are incorrect. A Medi-Cal Supplemental Changes – DHCS 6209 (Rev. 2/08) form is required to make necessary changes. Please attach a valid, legible copy of an official preprinted document from the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109C).
- The business type has changed (for example: sole proprietorship, corporation or partnership). Providers are required to complete a new Medi-Cal Provider Group Application – DHCS 6203 (Rev. 2/08); or a Medi-Cal Provider Application – DHCS 6204 (Rev. 2/08), Medi-Cal Disclosure Statement – DHCS 6207 (Rev. 2/15), and Medi-Cal Provider Agreement - DHCS 6208 (Rev. 11/11).
- Provider has incorporated. Attach a valid, legible copy of the Articles of Incorporation showing the name of the corporation and a legible copy of an official preprinted document from the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109-C).
- A provider's corporation is doing business under a fictitious name. Attach a valid, legible copy of the fictitious name permit issued by the Dental Board of California.

To obtain a current application form, please contact Denti-Cal toll-free at (800) 423-0507 or visit the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=ApplicationForms. Failure to submit the appropriate form(s) and supporting documentation will delay the processing of the enrollment application and it will be returned as incomplete.

To obtain the Tax Identification Change Form, please visit the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

Tax Identification Change Information

TAX IDENTIFICATION CHANGE INFORMATION

Provider ID Number _____ Service Office Number _____

Doing Business As Name _____

Tax Identification Number ___ __ -__ __ - __ __ __ __ ***or*** __ __ - __ __ __ __
(SSN) (EIN)

Billing Provider Name _____
(Please Print)

Billing Provider's Signature _____ Date _____

No Claim Activity for 12 Months

In order to remain actively enrolled in the Denti-Cal Program, providers must comply with all enrollment requirements.

Denti-Cal Program providers will automatically be inactivated from the Denti-Cal Program if any of the following occurs:

- Dental license is expired, revoked, inactivated, denied renewal, or suspended by the Dental Board of California;
- Mail is returned by the post office marked "Undeliverable" due to incorrect address;
- Twelve months with no claim activity in the Denti-Cal Program.

Upon inactivation, providers will be required to re-apply to the Denti-Cal Program. To receive the most current enrollment application and information, please request an application by calling the Telephone Service Center at (800) 423-0507 or going to the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=ApplicationForms.

As a participating Denti-Cal provider, it is important to keep Denti-Cal records up to date by promptly reporting any changes to previously submitted information, e.g. name and address changes, the addition of associates or the sale of a practice. Providers must notify Denti-Cal in writing to change or correct your provider name/address information. Denti-Cal must receive a signed authorization within 35 days from the date the change occurred in order to make any changes to provider information records.

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers 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.

To remain active in the Denti-Cal Program, complete the form on the previous page and mail it to:

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

If the form is not received by Denti-Cal prior to the end of the 12-month period, the provider number will be deactivated. If a provider number is deactivated, the provider must reapply for enrollment in the Denti-Cal Program. To request an enrollment package contact Denti-Cal toll free at (800) 423-0507.

The No Claim Activity form is available on the Denti-Cal Web site: http://www.denti-cal.ca.gov/.

Voluntary Termination of Provider Participation

A provider may terminate his or her participation in the Denti-Cal Program at any time. Written notification of voluntary termination must include the provider's original signature, in blue or black ink (rubber stamps are not acceptable), and a current copy of the provider's driver's license must be attached for signature verification. Send to:

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

No Claim Activity for 12 Months

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period 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 bottom portion of this form and mail to: Denti-Cal, Medi-Cal Dental Program, P.O. 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.

Yes, I wish to remain a provider in the Denti-Cal Program because:

_____

Check the box that applies to your practice:

☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)

_____ _____
Provider Name Provider Number

_____ _____ CA _____
Provider Address City State Zip Code

Print Form

Submit Form

Reset Form

(R 01/2014)

Enrollment of Billing Intermediaries

Denti-Cal providers who use a billing intermediary for claims preparation and submission must notify Denti-Cal of their billing arrangements. A billing intermediary may include any entity, such as a partnership, corporation, sole proprietorship or individual, contracted with a provider to bill the Denti-Cal program on his or her behalf. A provider's salaried employees are not considered billing intermediaries.

A provider who wishes to use a billing service must complete a Medi-Cal Dental Provider and Billing Intermediary Application/Agreement and send it to Denti-Cal. A provider should use this form to notify Denti-Cal of the initiation, renewal or termination of a billing intermediary contract. Billing services submitting claims to Denti-Cal must register with the Denti-Cal Program by completing a Billing Intermediary Registration Form. Upon registration, Denti-Cal will assign a registration number which the billing service must include on all claims submitted. To obtain either a Medi-Cal Dental Provider and Billing Intermediary Application/Agreement or a Billing Intermediary Registration Form, providers should call Denti-Cal toll-free at (800) 423-0507 or write to:

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

When a provider notifies Denti-Cal of billing service arrangements, Denti-Cal will acknowledge the notification within 10 days. Denti-Cal will also notify a provider when one of the following occurs:

- A billing intermediary notifies Denti-Cal that it has contracted with a provider;
- A billing intermediary notifies Denti-Cal that it has terminated its contract with a provider;
- A billing intermediary that submits claims for a provider notifies Denti-Cal that it is withdrawing its registration as a Denti-Cal billing intermediary;
- The Department instructs Denti-Cal to withdraw the registration of a provider's billing intermediary.

MEDI-CAL DENTAL PROVIDER AND BILLING INTERMEDIARY APPLICATION/AGREEMENT

Important:

- Type or print clearly, in blue ink.
- If you make corrections, please line through, date, and initial correction in ink.
- For Medi-Cal return completed Application/Agreement to:

Medi-Cal Dental Program (Denti-Cal)
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

(1) **Type of Request:** ☐ Initial Registration ☐ Terminate Registration ☐ Add Provider(s) ☐ Delete Provider(s)

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

PROVIDER INFORMATION			
(2) Provider Name (full legal)			
(3) Doing Business Name (if applicable)	(4) National Provider Identifier (NPI)		
(5) Provider Service Address (number, street)	City	State	ZIP Code
(6) Contract Begin Date (mm/dd/yyyy) / /	(7) Contract End Date (mm/dd/yyyy) / /		New Contract Yes ☐ No ☐
(8) Contact Person Title/Position	Email Address		
Contact telephone number ( )	Driver's License or State-Issued Identification Number and State of Issuance (attach a legible copy)		

BILLER INFORMATION (If other than the provider of service)			
(9) Owner Name (full legal name with 5% or more ownership/interest)		Biller Service Telephone Number ( )	
(10) Biller Service Registration Number	Taxpayer Identification Number (TIN) issued by the IRS	Business License/Tax Certificate Number	
(11) Business Address (number, street)	City	State	Zip
(12) Owner contact number ( )	Driver's License or State-Issued Identification Number and State of Issuance (attach a legible copy)		
Full legal name(s) required as and any assumed Business names(s), address(es), and National Provider Identifier(s).			

Sample

Submit a legible copy of the following documents (required)

- Provider and Billing Intermediary Application/Agreement
- Billing Intermediary Service Contract(s)/Agreement(s)
- Biller Business License/Tax Certificate
- Provider Driver's License or State-Issued Identification Number Card
- Biller Driver's License or State-Issued Identification Number Card

The Provider and Biller agree to provide Denti-Cal with the above information requested in order to verify qualifications to act as a Medi-Cal Dental Intermediary Biller.

(13)

PROVIDER SIGNATURE INFORMATION	
Full Printed Name	Title
Provider Signature (original signature required)	Date (mm/dd/yyyy) / /
BILLING SERVICE SIGNATURE INFORMATION	
Full Printed Name	Title
Owner (original signature required)	Date (mm/dd/yyyy) / /

DTN: B-PRV-FRM-026 Version: A Print Date: 2/9/2012 Page 1 of 2

MEDI-CAL DENTAL PROVIDER AND BILLING INTERMEDIARY APPLICATION/AGREEMENT

The Provider/Biller hereby acknowledges that he/she has read and understands the Medi-Cal Dental Program Provider Handbook and its contents, and agrees to comply with all Medi-Cal and Denti-Cal requirements, to include future updates as posted on the Denti-Cal web site: www.denti-cal.ca.gov

For a minimum period of five (5) years the Provider/Biller agrees to keep and maintain records of each such service rendered, the beneficiary or person to whom rendered, the date the service was rendered, and such additional information, which may be required by regulation. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to the California Department of Health Care Services; California Department of Justice; Bureau of Medi-Cal Fraud, Office of the State Controller; California Department of Corporations; U. S. Department of Health and Human Services, or their duly authorized representatives.

The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds, and decertification of the Provider/Biller from participation in the Medi-Cal program and/or billing either electronically or manually.

The Provider/Biller agrees not to submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary or from other persons on behalf of the beneficiary for any service included in the Medi-Cal program's scope of benefits in addition to claims submitted to the Medi-Cal program for that service, except to collect payments due where the benefits available under the Medi-Cal program duplicate those provided under other contractual or legal entitlements of the person or persons receiving them.

The Provider further agrees that dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability, marital status, or sexual orientation.

Sample

13 PROVIDER SIGNATURE INFORMATION		
Full Printed Name	Title	
Provider Signature (original signature required)		Date (mm/dd/yyyy) / /
BILLING SERVICE SIGNATURE INFORMATION		
Full Printed Name	Title	
Owner (original signature required)		Date (mm/dd/yyyy) / /

DTN: B-PRV-FRM-026 Version: A Print Date: 2/9/2012 Page 2 of 2

How to Complete the Medi-Cal Dental Provider and Billing Intermediary Application/Agreement

Providers must use this form to notify Denti-Cal when they initiate, renew or terminate a contract with a billing intermediary. The form contains the following:

1. **Type of Request**: Use an "X" to indicate the request type:
   - Initial Registration
   - Add Provider(s)
   - Terminate Registration
   - Delete Provider(s)
2. **Provider Name (full legal)**: Enter the provider's name.
3. **Doing Business Name (if applicable)**: Enter the provider's "Doing Business As" name.
4. **National Provider Identifier (NPI)**: Enter the provider's NPI number.
5. **Provider Service Address (number, street)**: Enter the provider's street address, city, state, and zip code in these fields.
6. **Contract Begin Date (mm/dd/yyyy)**: Beginning date of the contract between the provider and the billing intermediary.
7. **Contract End Date (mm/dd/yyyy)**: Date the contract between the provider and billing intermediary will end (unless it is renewed).
8. **Contact Person Title/Position**: Enter the name, title, e-mail address, telephone number (with area code), and driver's license or state-issued identification and state of issuance in these fields.

If the biller's information is different than the provider of services, then complete the following sections:

9. **Owner Name (full legal name with 5% or more ownership/interest)**: Enter the owner's name and telephone number.
10. **Biller Service Registration Number**: The registration number assigned to the billing intermediary, if applicable. (NOTE: The assigned registration number may not yet be available to a provider who is notifying Denti-Cal of a new contract with a billing service, especially if the billing service has not yet registered with Denti-Cal).
11. **Business Address (number, street)**: Complete the fields for the billing service's address, including street address, city, state and zip code.
12. **Owner contact number**: Enter the owner's telephone number (with area code) and driver's license or state-issued identification and state of issuance in these fields.
13. **PROVIDER SIGNATURE INFORMATION/BILLING SERVICE SIGNATURE INFORMATION**: Both the provider and the billing service need to sign both page one and page two of the form.

When submitting the form, make sure to include the following:

- Provider and Billing Intermediary Application/Agreement
- Billing Intermediary Service Contract(s)/Agreement(s)
- Biller Business License/Tax Certificate
- Provider Driver's License or State-Issued Identification Number Card
- Biller Driver's License or State-Issued Identification Number Card

Electronic Data Interchange (EDI)

To submit documents and receive corresponding reports electronically, dentists who have enrolled and are certified to participate in the Denti-Cal Program must apply and be approved by Denti-Cal to participate in the EDI program. The Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement (for electronic claim submission), hereinafter "Trading Partner Agreement," must be signed and submitted along with the Provider Service Office Electronic Data Interchange Option Selection Form. Failure or refusal to sign this Agreement may be grounds for immediate suspension from participation in the electronic claims submission program pursuant to Title 22, California Code of Regulations (CCR) §51502.1(j). This Agreement is also required for EDI clearinghouses and billing intermediaries billing electronically on behalf of Denti-Cal providers. Providers can also authorize Denti-Cal to provide remittance data electronically by completing the Electronic Remittance Advice (ERA) Enrollment Form.

When a provider is enrolled in the Denti-Cal EDI program, Denti-Cal sends the provider a letter confirming the provider's EDI enrollment. Confirmation is also sent by e-mail if a valid e-mail address is available.

"Section 6: Forms" of this Handbook gives instructions for completing all required billing forms. Denti-Cal's Electronic Data Interchange (EDI) service gives participating providers the option of submitting many of these completed treatment forms electronically to Denti-Cal and receiving related information electronically.

HIPAA-Compliant Electronic Format Only

Denti-Cal accepts only the HIPAA-compliant electronic format for claims (ASC X12N 837) and claim status (ASC X12N 276) from certified trading partners. A provider submitting claims electronically is required to undergo certification for the HIPAA-compliant format. However, if a provider is submitting claims electronically through its contracted clearinghouse, only the clearinghouse must be certified. In this case, a provider must ensure that its contracting clearinghouse has been certified through Denti-Cal, prior to submitting claims.

Ineligibility for EDI

A Denti-Cal provider is not eligible for EDI if, within the past three years, criminal charges were filed against the provider for fraudulently billing the Medi-Cal program, or if the provider has been suspended from the Medi-Cal program, or has been required to pay recovery to Medi-Cal for overpayments in excess of 10 percent of the provider's total annual Medi-Cal income.

If a Denti-Cal provider has been placed on Prior Authorization (PA) and/or Special Claims Review (SCR), submitting electronically is still possible. Providers must flag the radiograph or the attachment indicator to "Y" (Yes) for procedures on PA and/or SCR to avoid the claim from being denied.

A copy of the HIPAA Transaction Standard Companion Guide (Denti-Cal EDI Companion Guide), as well as the Trading Partner Agreement, can be obtained by phoning Telephone Service Center toll-free at (800) 423-0507 or (916) 853-7373 and asking for EDI Support. Requests may also be sent by e-mail to denti-caledi@delta.org.

STATE OF CALIFORNIA – CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL DENTAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT
(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES
This agreement is between the State of California, California Department of Health Care Services, hereinafter referred to as the "Department" and:

PROVIDER INFORMATION			
Provider name (full legal)			
Business Name (if applicable)	National Provider Identifier (NPI)		
Provider service address (number, street)	City	State	ZIP Code
Contact person	Email Address		
Contact person address (number, street)	City	State	ZIP Code
Contact telephone number ( )	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
BILLER INFORMATION (If other than the provider of service)			
Biller name (full legal)	Biller telephone number ( )		
Business Name (if applicable)	Email Address		
Business Address (number, street)	City	State	Zip
Contact Person	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
Full legal name(s) required as well as any assumed Business names(s), address(es), and National Provider Identifier(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."			

1.1 ELECTRONIC DATA INTERCHANGE (EDI) DATA TYPES
This Agreement applies to the following EDI Data Types, when available: (Refer to Provider Service Office Electronic Data Interchange Option Selection Form)
ANSI X 12 837 (Claims/TARs/RTDs/NOAs/Adjustments)
ANSI X 12 276/277 (Claim Status Inquiry/Responses)
ANSI X 12 835 (Claim Payment/Remittance Advice)

1.2 BACKGROUND INFORMATION
The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal Dental electronic Biller.

2.0 DEFINITIONS
The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING
The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Denti-Cal Provider Handbook. The Provider hereby acknowledges that he or she has read, and understands the Provider Handbook and its contents, and agrees to read and comply with all Provider Handbook updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION
The Provider agrees by claims submission and certifies under penalty of perjury that all services for which claims are submitted electronically have been personally provided to the patient by the Provider or under his or her direction by another person eligible under the Medi-Cal program to provide such services, and such person(s)

B-EDI-FRM-022.C (Revised 06/11) Page 1 of 4

Sample Provider Service Office Electronic Data Interchange Option Selection Form

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507 Web www.denti-cal.ca.gov

PROVIDER SERVICE OFFICE ELECTRONIC DATA INTERCHANGE OPTION SELECTION FORM

Reason for Submission: ○ New Enrollment ○ Change Enrollment ○ Cancel Enrollment

Provider Name:	National Provider Identifier (NPI):		
Doing Business As Name (DBA):			
Provider Address – Street:	City:	State:	ZIP Code:
Provider Contact Name:	Telephone Number:		
Software/Practice Management System:	Email Address:		

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 853-7373 or by email to denti-caledi@delta.org.

INPUT FROM:
○ Service Office (SO)
○ Billing Office (BO)
○ Clearinghouse (CH) NAME: _____

You will submit Claims, TARs and Adjustments (ANSI X 12 837).
Will you also submit NOAs electronically? ○ **YES** ○ **NO**
Will you also submit Claim Status Inquiry (ANSI X 12 276)? ○ **YES** ○ **NO**

RETURN OUTPUT OPTIONS when available (shaded options are standard or mandatory):

EDI Document
Electronic RTDs ○ **YES** ○ **NO**
Electronic NOAs ○ **YES** ○ **NO**
Electronic EOB Supplemental Claim Data (If YES: ○ SUMMARY or ○ DETAIL) ○ **YES** ○ **NO**
*Would you like to stop receiving Explanations of Benefits (EOBs) by mail? ○ **YES*** ○ **NO**

**If YES, EDI Support will contact your office to determine the effective date.*
*NOTE: Opting not to receive paper EOBs by mail is an option **only** if either the 835 ERA and/or Supplemental EOB file in the Detail format are received.*

Electronic X-Ray/Attachment Labels (If YES: ○ 1-UP or ○ 3-UP) ⊙ **YES**
Report of Documents Awaiting Return Information (CP-0-978-P) ⊙ **YES**
Report of EDI Documents Received (CP-0-973-P) ⊙ **YES**
Claim Status Inquiry Response (ANSI X 12 277) ○ **YES** ○ **NO**

_____ **Authorized Signature** _____ **Submission Date**

Return completed form to: Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609

For Denti-Cal Use Only:	*C/H ID:*	*Remote ID:*	*P/W:*	*CV:*

This page intentionally left blank.

Sample Electronic Remittance Advice (ERA) Enrollment Form - Page 1

Print Form

Reset Form

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507 Web www.denti-cal.ca.gov

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

PROVIDER INFORMATION			
1. Provider Name	2. Doing Business As Name (DBA)		
3. Provider Address – Street	4. City	5. State/Province	6. ZIP Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION	
7. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	8. National Provider Identifier (NPI)

PROVIDER CONTACT INFORMATION		
9. Provider Contact Name	10. Telephone Number	11. Email Address

ELECTRONIC REMITTANCE ADVICE INFORMATION Preference for Aggregation of Remittance Data (Account Number Linkage to Provider Identifier)
12. National Provider Identifier (NPI)
13. Method of Retrieval: The only method of retrieval from Denti-Cal is Secure FTP

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION
14. Clearinghouse Name

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION
15. Vendor Name

16. **Reason for Submission:** ○ New Enrollment ○ Change Enrollment ○ Cancel Enrollment

17. _____ **Authorized Signature** _____ **Submission Date**

_____ **Printed Name of Person Submitting Enrollment**

Mail the completed form to: Denti-Cal, Attention: Provider Enrollment Department, P.O. Box 15609, Sacramento, CA 95852-0609.
To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org).
Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

For Denti-Cal Use Only:	*Date Entered:*		*Initials:*	

DTN: B-EDI-FRM-048.A

Instructions for Completing the Electronic Remittance Advice (ERA) Enrollment Form

By submitting this form, the provider is authorizing Denti-Cal to provide remittance data electronically.

The ERA is the v5010 X12 835 transaction. For assistance in completing the Electronic Remittance Advice (ERA) Enrollment form, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org). These instructions may also be found in the EDI section on the Denti-Cal website at www.denti-cal.ca.gov.

PROVIDER INFORMATION

1. Enter the provider name
2. If using a doing business as name (DBA) enter the DBA
3. Enter the provider service office street address
4. Enter the service office city
5. Enter the service office state
6. Enter the service office zip code

PROVIDER IDENTIFIERS INFORMATION

7. Depending on how earnings are reported enter the provider tax identification number (TIN) or Employer Identification number (EIN) or Social Security Number (SSN)
8. Enter the provider National Provider Identifier (NPI) for the service office location

PROVIDER CONTACT INFORMATION

9. Enter the contact name
10. Enter the telephone number for the service office
11. Enter the provider email address

ELECTRONIC REMITTANCE ADVICE INFORMATION

12. Enter the provider National Provider Identifier (NPI) for the service office location; must match the preference for ERA payment.
13. Method of retrieval: The only method of retrieval from Denti-Cal is Secure FTP.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

14. If applicable, enter the name of the provider's Electronic Data Interchange (EDI) clearinghouse

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

15. If applicable, enter the name of the provider's Practice Management System/Software vendor

REASON FOR SUBMISSION

16. Check the ERA action "New Enrollment", "Change Enrollment" or Cancel Enrollment"

OTHER

17. Sign and date the ERA form; requires the provider's original signature

Mail the completed form to: Denti-Cal
Attention: Provider Enrollment Department
P.O. Box 15609
Sacramento, CA 95852-0609.

To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org). Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

Electronic Claims Submission and Payment Services

Submitting claims electronically reduces processing time for claims, makes billing and tracking documents easier, and helps maximize computer capabilities. EDI-enrolled providers can also receive the Notice of Authorization (NOA) and Resubmission Turnaround Document (RTD) forms electronically along with other EDI reports.

For an EDI Enrollment Packet, please contact Provider Services toll-free at (800) 423-0507. For an EDI How-To Guide or other information on submitting Denti-Cal claims and Treatment Authorization Requests (TARs) electronically, please call EDI Support at (916) 853-7373. Requests may also be sent by e-mail to denti-caledi@delta.org. Providers may also access EDI enrollment forms and Guides from the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=EDI.

A dental office wishing to use EDI must have a computer system that includes an internet connection and a software program that will allow the transmission of claims. If the office already has a computer, check with the practice management system vendor to determine if the software will enable submitting of claims electronically to Denti-Cal. The software vendor can also assist in determining the best computer hardware and software options for electronic claims processing needs.

EDI enrollment allows providers to send TARs, claims and NOAs for payment, over the telephone line or through File Transfer Protocol (FTP) directly from the office to Denti-Cal, or through a billing intermediary or clearinghouse. EDI gives providers the option of receiving claims-related information electronically from Denti-Cal, such as reports, Explanation of Benefits (EOBs) and Electronic Remittance Advice (ERA) data for performing automated accounts receivable reconciliation.

EDI Providers who receive the 835 Electronic Remittance Advice (ERA) and/or Supplemental EOB file in Detail format may opt to discontinue receiving paper EOBs. In order to stop receiving paper EOBs, providers enrolled to submit electronically must complete and submit the Provider Service Office Electronic Data Interchange Option Selection form reflecting that option. The decision to not receive a paper EOB will not affect the mailing of a provider's checks.

The EDI system format also allows the electronic submission of comments which may be pertinent to the treatment requested or provided. Denti-Cal provides identification labels and specially marked envelopes for mailing additional information (such as radiographs, periodontal charting, or other documentation) which may be required to process electronically submitted treatment forms.

Use red-bordered EDI envelopes and EDI labels only when Denti-Cal requests them through the "X-Ray/Attachment Request" report (CP-O-971-P).

Use green-bordered envelopes when submitting claims, NOAs and RTDs (conventional paper forms) or those made available electronically that are printed onto paper and mailed in for processing as well as Claim Inquiry Forms (CIFs). No EDI labels on EDI RTDs or NOAs, please.

What Can Be Sent Electronically to Denti-Cal

The following items can be transmitted electronically:

- Claims,
- TARs,
- NOAs for payment when treatment is completed (if the system or clearinghouse can accept them; only selected software and clearinghouses include the EDI NOA feature).
- Radiographs,
- Periodontal evaluation charts,
- Justification of Need for Prosthesis Forms (DC054), and
- Narrative documentation (surgical reports, etc.)

The following items **cannot** be transmitted electronically and **must** be mailed to Denti-Cal:

- Completed RTDs (even those provided electronically that are printed on paper),
- NOAs (if the system cannot submit them electronically),
- requests for reevaluation,

- CIFs, RTDs, or NOAS issued for paper or EDI documents, and/or
- Any documentation related to claims and TARs submitted on paper.

Within 24 to 48 hours after sending documents electronically, Denti-Cal provides an acknowledgement report to confirm receipt of claims and TARs (CP-O-973-P: Daily EDI Documents Received Today). Another report (CP-O-971-P: X-Ray/Attachment Request) is issued the same day the acknowledgement report is issued if documentation is needed.

It is important to review these reports to verify submitted forms and documentation are being received by Denti-Cal. If these reports are not being received, check with your vendor, clearinghouse, or EDI Support.

Sending Radiographs and Attachments

Providers should maintain a supply of EDI labels and envelopes (small and large X-ray envelopes, and mailing envelopes) which are printed in red ink. When entering the document into the practice management system, determine whether radiographs or documentation are needed. If so prepare EDI labels and envelopes:

- Insert the radiographs into an EDI X-ray envelope.
- Affix a blank label onto the outside of the envelope.
- Staple any necessary documentation, such as a Justification of Need for Prosthesis form (DC054) or periodontal chart, onto the outside of the X-ray envelope.
- Write the patient's name under “BIC” to help you identify the patient.

Upon receipt of the X-ray/Attachment Request report, write the 11-digit Base DCN next to “Denti-Cal DCN” and mail it to Denti-Cal in the large mailing envelope marked with the special EDI post office box.

Attachments, such as claims information, transmitted electronically to Denti-Cal are delivered to Denti-Cal's computer system for processing. Denti-Cal providers may use EDI to submit treatment forms and receive reports and other electronic data 24 hours per day Monday through Saturday, and from 12 noon to 12 a.m. on Sunday (excluding holidays). Electronic documents received at Denti-Cal by 6:00 p.m. Monday through Saturday are entered into EDI processing the same evening. Staff are also available to answer EDI-related questions and assist with any problems an office may be experiencing with electronic claims transmission Monday through Friday during normal work hours.

Digitized Images and EDI Documents

In conjunction with electronically submitted documents, Denti-Cal accepts digitized images submitted through electronic attachment vendors: National Electronic Attachment, Inc. (NEA), National Information Services (NIS) and Tesia Clearinghouse, LLC.

Providers must be enrolled to submit documents electronically prior to submitting digitized images. For more information regarding digitized images and EDI enrollment, please contact:

- Telephone Service Center toll-free, (800) 423-0507
- EDI Support, (916) 853-7373
- e-mail: denti-caledi@delta.org

Digitized Imaging Vendor and Document Specifications

Digitized radiographs, photographs, periodontal evaluation charts, scanned State-approved Justification of Need for Prosthesis forms (DC054), and other narrative reports may be submitted in conjunction with EDI claims and TARs through NEA, NIS or Tesia Clearinghouse, LLC Web sites.

NEA Users: Digitized radiographs and attachments must be transmitted to NEA before submitting an EDI document. NEA’s reference number must be entered on the EDI claim or TAR in the following format: “**NEA#” followed by the reference number, with no spaces - Example: NEA#9999999**. It is important to use this format and sequence.

Some dental practice management and electronic claims clearinghouse software have an interface with NEA that automatically enters the reference number into the notes of the claim. For additional

information, providers can visit http://www.nea-fast.com or call (800) 782-5150

NIS Users: The EDI document should be created. Before transmitting a document electronically, the digitized radiographs and attachments should be attached. The Document Center should be used to scan images of Denti-Cal's Justification of Need for Prosthesis Form (DC054), perio charts, photos, etc. The date images were created should be entered in the notes for each attachment. For additional information, providers can visit www.nationalinfo.com or call (800) 734-5561.

Tesia Clearinghouse, LLC Users: Create the claim or TAR. Before transmitting a document electronically, the digitized images should be created and attached. Each attachment must include the date the images were created. For additional information, providers can visit www.tesia.com or call (800) 724-7240.

Please note:

- Images should not be transmitted for EDI claims or TARs that are already waiting for radiographs and/or attachments to be mailed.
- Digitized images of Claim Inquiry Forms (CIFs), Resubmission Turnaround Documents (RTDs) and Notices of Authorization (NOAs) or digitized images related to paper documents cannot be processed.
- When submitting CIFs by mail, providers have the option of not submitting hard copies of radiographs and other documentation related to a CIF if the provider indicates digitized image reference numbers in the form's remarks box. If a provider chooses not to include digitized image reference numbers on a CIF, the provider must send in hard copies.
- Denti-Cal is unable to respond to inquiries submitted through digitized imaging vendors' Web sites. Instead, CIFs should be mailed to Denti-Cal.
- Radiographs are not required for dentures on edentulous patients. Submit Justification of Need for Prosthesis forms (DC054) only.

Medi-Cal Dental Patient Referral Service

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 California'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 Medi-Cal Dental Patient Referral Service Form. Return the completed form in one of the following ways:

Mail:	California Medi-Cal Dental Program Attn: Enrollment Department PO Box 15609 Sacramento, CA 95852-0609
E-mail:	Denti-CalEnrollmentDept@delta.org Send a scanned image of the completed form to the e-mail address above.
Fax	916-631-1191

If you have any questions about the form or the referral service, please contact the Denti-Call Telephone Service Center at (800) 423-0507.

Sample Medi-Cal Dental Patient Referral Service Form - Page 1

Medi-Cal Dental Patient Referral Service

☐ Yes I would like Denti-Cal patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this list at any time.

☐ No I do not want Denti-Cal patients referred to my office. Please do not include my name on your referral list.

Dental License # _____ **NPI #** _____ **Billing Provider ID** _____ **Service Office #** _____

Provider Name: _____
Business Name: _____
Office Address: _____
Phone Number: _____ Is your office wheelchair accessible? ☐ Yes ☐ No
Email Address: _____

Approximately how many more Dent-Cal patients can you accept in your practice? _____

What other languages are spoken in your office? _____

Are you a board-certified or board-eligible specialist? ☐ Yes ☐ No If yes, please list your specialties:

Specialty:_____ ☐ Board Certified ☐ Board Eligible
Specialty:_____ ☐ Board Certified ☐ Board Eligible
Specialty:_____ ☐ Board Certified ☐ Board Eligible

Are there rendering providers in your office that are board-certified or board-eligible specialists?
☐ Yes ☐ No If yes, please list the rendering provider(s) and specialties in space indicated on back of page.

List any dental specialties or services offered in your office (i.e. endodontic, periodontal, oral surgery, procedures, general anesthesia, etc.): _____
_____

What ages of children do you see in this practice? [*Select the appropriate number*]

1	2	3	4	5	6	7	8	9	10	11	12
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Special needs accepted (*Select all that apply*):

___ No ___ Motor impairment ___ Seizures
___ Mildly challenging behavior ___ Cognitive impairment

Mail, email, fax or call Denti-Cal to be added to the referral list!

Mail form to:	**Email form to:**	**Fax form to:**	**Call Denti-Cal at:**
Denti-Cal Attn: Provider Enrollment P.O. Box 15609 Sacramento, CA 95852-0609	Denti-CalEnrollmentDept@delta.org	916-631-1191	**1-800-423-0507** Speak with a representative to answer questions by phone!

Sample Medi-Cal Dental Patient Referral Service Form - Page 2

Rendering providers in your office that are board-certified or board-eligible specialists:

Name: _____ Name: _____
Dental Lic. #: _____ Dental Lic. #: _____
Specialties: _____ Specialties: _____
☐ Board Certified ☐ Board Eligible ☐ Board Certified ☐ Board Eligible

Name: _____ Name: _____
Dental Lic. #: _____ Dental Lic. #: _____
Specialties: _____ Specialties: _____
☐ Board Certified ☐ Board Eligible ☐ Board Certified ☐ Board Eligible

Name: _____ Name: _____
Dental Lic. #: _____ Dental Lic. #: _____
Specialties: _____ Specialties: _____
☐ Board Certified ☐ Board Eligible ☐ Board Certified ☐ Board Eligible

Name: _____ Name: _____
Dental Lic. #: _____ Dental Lic. #: _____
Specialties: _____ Specialties: _____
☐ Board Certified ☐ Board Eligible ☐ Board Certified ☐ Board Eligible

Name: _____ Name: _____
Dental Lic. #: _____ Dental Lic. #: _____
Specialties: _____ Specialties: _____
☐ Board Certified ☐ Board Eligible ☐ Board Certified ☐ Board Eligible

Comments: _____

www.denti-cal.ca.gov

Print Form

Reset Form

Submit by Email

Mail, email, fax or call Denti-Cal to be added to the referral list!

Mail form to:	**Email form to:**	**Fax form to:**	**Call Denti-Cal at:**
Denti-Cal Attn: Provider Enrollment P.O. Box 15609 Sacramento, CA 95852-0609	Denti-CalEnrollmentDept@delta.org	916-631-1191	**1-800-423-0507** Speak with a representative to answer questions by phone!

Electronic Funds Transfer of Payment

Denti-Cal offers electronic funds transfer of Denti-Cal payments to a designated checking or savings account. To begin participating in electronic funds transfer, you must complete and sign an Electronic Funds Transfer Enrollment Form. Forms may be requested by calling Provider Services 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

Instructions for completing the Electronic Funds Transfer Enrollment Form are contained on the back of the form. Mail the completed form to Denti-Cal at the address shown above. Please be sure to sign and date the form. To be accepted for processing, the Electronic Funds Transfer Enrollment Form must contain the provider's original signature, in blue or black ink (rubber stamps are not acceptable), and a preprinted, voided check must be attached.

Upon receipt of the Electronic Funds Transfer Enrollment Form, Denti-Cal will ensure the designated bank participates in electronic funds transfer. To verify account information, Denti-Cal will send a “test” deposit to the bank; there will be a “zero” deposit to the account for that payment date. The test cycle usually takes three to four weeks to complete. During the test cycle period, the provider will continue to receive Denti-Cal payment checks through the mail.

Each time Denti-Cal deposits a payment directly to an account, a statement confirming the amount of the deposit will appear on the Explanation of Benefits.

Contact Denti-Cal to change or discontinue electronic funds transfer of Denti-Cal checks. To change banks or close an account, send Denti-Cal a written authorization to discontinue electronic funds transfer of Denti-Cal checks.

Sample Electronic Funds Transfer of Enrollment Form

Print Form

Reset Form

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507 Web www.denti-cal.ca.gov

ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM

PROVIDER INFORMATION			
1. Provider Name:	2. Doing Business As Name (DBA):		
3. Provider Address—Street:	4. City:	5. State/Province:	6. ZIP Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION	
7. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	8. National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION		
9. Provider Contact Name:	10. Telephone Number:	11. Email Address:

FINANCIAL INSTITUTION INFORMATION	
12. Financial Institution Name:	13. Financial Institution Routing Number:

14. **Type of Account at Financial Institution:** ○ Checking ○ Savings

15. Provider's Account Number with Financial Institution:	16. Account Number Linkage to Provider Identifier (NPI):

17. **Reason for Submission:** ○ New Enrollment ○ Change Enrollment ○ Cancel Enrollment

18 **INCLUDE WITH ENROLLMENT SUBMISSION**

VOIDED CHECK

***** TAPE HERE OR ATTACH BANK LETTER *****

19

Authorized Signature - Written Signature of Person Submitting Enrollment **Submission Date**

Printed Name of Person Submitting Enrollment

Mail the completed form to: Denti-Cal, Attention: Provider Enrollment Department, P.O. Box 15609, Sacramento, CA 95852-0609.
To check status, call (800) 423-0507.

To research and resolve a late or missing Healthcare EFT Standards payment, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.
Late or missing is defined as a maximum elapsed time of four business days following the receipt of the associated v5010X12 835 transaction.

For Denti-Cal Use Only:	*Date Entered:*	*Initials:*

Section 4 - Treating Beneficiaries

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Section 4 - Treating Beneficiaries

Beneficiary Identification

Medi-Cal Benefits Identification Card

Denti-Cal does not determine the eligibility of beneficiaries. Eligibility for the Denti-Cal Program is determined by a County Social Services office and reported to the State of California. The State, in turn, issues a

Medi-Cal Benefits Identification Card (BIC) to beneficiaries who are eligible for Medi-Cal benefits. The BIC serves as a permanent identification for a Medi-Cal beneficiary; however, possession of the card does not guarantee eligibility for Medi-Cal benefits, since the card can be retained by the beneficiary whether or not the beneficiary is eligible for the current month.

For more information, see the following Web site: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/eligreccrd_z01.doc.

BIC cards are 3 ⅛ inches long and 2 ⅜ inches wide with a white background. The lettering is blue on the front and black on the back. Printed on the front of the card is a

14-character alphanumeric identification (ID) number. The ID number is comprised of a nine-character alphanumeric, a check digit and a four-digit Julian date matching the issue date of the BIC.

Only California Children's Services (CCS) beneficiaries will have a BIC with a 10-character ID. All other Medi-Cal beneficiaries have received a BIC with a 14-character ID. If beneficiaries have not received the 14-character BIC ID, refer them to their local county office.

Figure 4-1, CCS Number (Numeric, 10 digit)

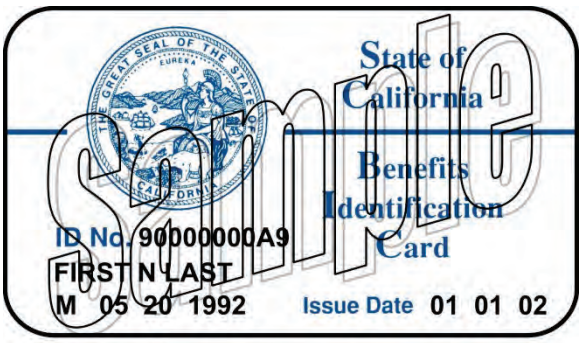


Figure 4-2, Pseudo SSN (Alphanumeric, 10 characters)

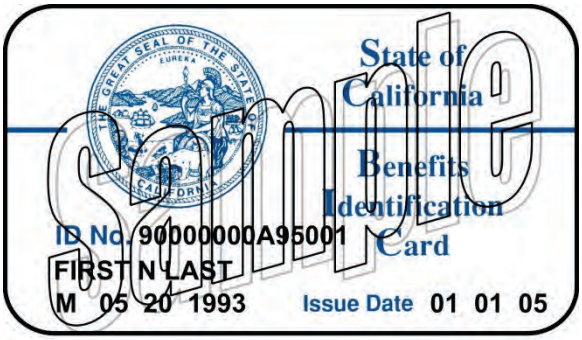


Figure 4-3, 14 Digit BIC Number (Alphanumeric, 14 characters)

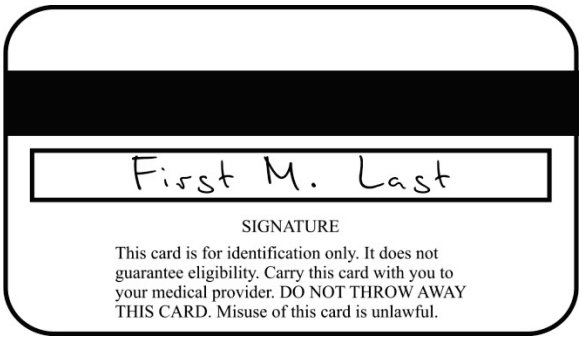


Figure 4-4, BIC (Back)

Special Programs Identification Cards

Some Medi-Cal beneficiaries may be enrolled in special programs, such as prepaid health plans and pilot projects. A beneficiary enrolled in one of these plans who is eligible for dental services should have an identification card from the plan as well as possess a Medi-Cal Benefits Identification Card. A list of current special project and prepaid health plan codes can be found in "Section 9: Special Programs" of this Handbook.

Medi-Cal Identification Card for Presumptive Eligibility (MC 263 PREMEDCARD (4/96)) for Aid Code 7G

In order to receive payment for services provided to pregnant beneficiaries in Aid Code 7G, providers must submit a copy of the beneficiary's temporary Presumptive Eligibility (PE) card with their claim (see below for a sample of the card). The PE card is a required form of identification. Substitutions should not be accepted. This card is validated by the beneficiary's physician attending to the beneficiary's pregnancy and is valid until the Medi-Cal eligibility is determined or the PE period ends. This date is identified on the temporary PE card as the "First Good Thru" date. Some beneficiaries may be eligible for extended PE coverage. In such cases, the temporary PE card will have a "Second Good Thru" date, and sometimes additional "Good Thru" dates. Once approved for Medi-Cal, the beneficiary will receive a plastic BIC.

Providers will only be paid for claims with dates of service that are between the effective date (the date the beneficiary signs the card) and the latest "Good Thru" date. The date of service must be within the validated time frame and, if not, providers should instruct the beneficiary to see a prenatal care provider, call an Eligibility Worker and/or a community advocate.

DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA

SIGNATURE/FIRMA: Jane Doe DATE/FECHA: 09/19/99

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY

VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY

PROVIDER USE ONLY
MEDI-CAL APPLICATION FILED:
PE PROVIDER SIGNATURE:
PE PROVIDER TITLE:
SECOND GOOD THRU:
PROVIDER STAMP HERE

MEDI-CAL ID: 12-7G-ZA34567-8-90
FIRST GOOD THRU: 10/31/99
PATIENT NAME: JANE DOE
DOB (MM/DD/YY): 123170

PE Provider Signature: John Jake, MD
PE Provider Title: M.D. Date: 09/19/99

Figure 4-5, Medi-Cal Identification Card Presumptive Eligibility

Immediate Need Cards

In certain situations, county welfare departments will issue Medi-Cal beneficiaries temporary BICs to Immediate Need and Minor Consent Program recipients (see below for a sample of the card).

The ID number ("ID NO.") is the 14-character BIC ID: this is used to access the Medi-Cal Eligibility Verification System. Prior to rendering services, providers must verify the beneficiary's eligibility and that the beneficiary with the BIC is the individual to whom the card was issued.

Temporary BICs issued to Immediate Need recipients are valid for identification purposes for 30 days, as indicated on the "ISSUE DATE:" and "GOOD THRU:" lines. The valid dates may occur in two consecutive months and are only used for identification purposes. Providers must verify the beneficiary's eligibility through a Point of Service (POS) network before rendering services.

The temporary BICs received by Minor Consent Program recipients are valid for identification for one year. However, the recipient is only eligible for the requested month. The "Issue Date:" and "Good Thru:" dates are for identification purposes only: providers must still verify the beneficiary's eligibility through a POS network before rendering services.

```
*************************************************************************
*                                                                       *
*                        STATE OF CALIFORNIA                            *
*                                                                       *
*                TEMPORARY BENEFITS IDENTIFICATION CARD                 *
*                                                                       *
*          ================================================             *
*          ===      FOR IDENTIFICATION PURPOSES ONLY      ===          *
*          ===     PROVIDER:  PLEASE VERIFY ELIGIBILITY   ===          *
*          ================================================             *
*                                                                       *
*   ID NO.  BICIDNUMBERXXX                    ISSUE DATE: MM/DD/YYYY    *
*                                             GOOD THRU : MM/DD/YYYY    *
*   FIRSTNAME I LASTNAME APL                                            *
*                                                                       *
*   F     MM/DD/YYYY                                                    *
*                                                                       *
*                                                                       *
*   SIGNATURE  ____________________________________________             *
*                                                                       *
*                  TERMVTAMCICSTRANYYYYMMDDHHMMSSDDDOPRXXXXXDISWRKR     *
*************************************************************************
```

Figure 4-6, Immediate Need Card

Verifying Beneficiary Identification

In certain instances, no identification verification is required, for example:

- When the beneficiary is 17 years of age or younger;
- When the beneficiary is receiving emergency services;
- When the beneficiary is a resident in a long-term care facility.

If the beneficiary is unknown to the provider, the provider is required to make a "good-faith" effort to verify the beneficiary's identification by matching the name and signature on the Medi-Cal issued ID to that on a valid photo identification, such as:

- A California driver's license;
- An identification card issued by the Department of Motor Vehicles;
- Any other document which appears to validate and establish identity.

The provider must retain a copy of this identification in the beneficiary's records. If there is a conflict in the beneficiary's Denti-Cal billing history where a provider bills or submits for authorization for a procedure that was previously performed by another provider, Denti-Cal will request that the current provider submit a copy of the beneficiary's identification to verify that the services are being provided to the appropriate beneficiary. If this situation occurs and the current provider cannot provide appropriate beneficiary identification, payment or authorization for treatment will be denied.

For additional information, please refer to Welfare & Institutions (W & I) Code 14017, 14017.5, 14018, and 14018.2(c).

Denti-Cal Beneficiary Eligibility

A Medi-Cal beneficiary is eligible for dental services provided under the Denti-Cal Program. However, limitations or restrictions of dental services may apply in certain situations to the following individuals:

- Those enrolled in a prepaid health plan which provides dental services;
- Those enrolled in another pilot program which provides dental services;
- Those who are assigned special aid codes;
- Those with minor consent restricted service cards.

According to state law, when a provider elects to verify Medi-Cal eligibility using a BIC, a paper identification card or a photocopy of a paper card and has obtained proof of eligibility, he or she has agreed to accept the beneficiary as a Medi-Cal beneficiary and to be bound by the rules and regulations of the Denti-Cal program.

Providers must verify eligibility every month for each recipient who presents a plastic Benefits Identification Card (BIC) or paper Immediate Need or Minor Consent card. Eligibility verified at the first of the month is valid for the entire month of service. A Point of Service (POS) printout or Internet eligibility response may be kept as evidence of proof of eligibility for the month.

Eligibility may be verified only for the current month and up to the previous 12 months, never for future months.

A person is considered a child until the last day of the month in which his/her 18th birthday occurs. After that particular month, he/she is considered an adult. However, a treatment plan authorized for a child is effective until completion if there is both continuing eligibility and dental necessity, regardless of change in age status.

Beneficiaries who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. Beneficiaries who can make a mark (X) in lieu of a signature will not be exempted from this requirement and will be required to make their mark on the Medi-Cal identification card. In addition, the signature requirement does not apply when a beneficiary is receiving emergency services, is 17 years of age or younger, or is a beneficiary residing in a long-term care facility.

If Medi-Cal eligibility is verified, the provider may not treat the beneficiary as a private-pay beneficiary to avoid billing the beneficiary's insurance, obtaining prior authorization (when necessary) or complying

with any other program requirement. In addition, upon obtaining eligibility verification, the provider cannot bill the beneficiary for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or SOC. Providers cannot bill beneficiaries for private insurance cost-sharing amounts such as deductibles, co-insurance or copayments.

Once eligibility verification has been established, a provider can decline to treat a beneficiary only under the following circumstances:

- The beneficiary has refused to pay or obligate to pay the required SOC.
- The beneficiary has limited Medi-Cal benefits and the requested service(s) is not covered by the Denti-Cal program.
- The beneficiary is required to receive the requested service(s) through a designated health plan. This includes cases in which the beneficiary is enrolled in a Medi-Cal managed care plan or has private insurance through a health maintenance organization or exclusive provider network and the provider is not a member provider of that health plan.
- The provider is unable to provide the particular service(s) that the beneficiary requires.
- The beneficiary is not eligible for Denti-Cal services.
- The beneficiary is unable to present corroborating identification with the BIC to verify that he or she is the individual to whom the BIC was issued.

A provider who declines to accept a Medi-Cal beneficiary must do so before accessing eligibility information except in the above circumstances. If the provider is unwilling to accept an individual as a Medi-Cal beneficiary, the provider has no authority to access the individual's confidential eligibility information.

Verifying Beneficiary Eligibility

The Point of Service (POS) network is set up to verify eligibility and perform Share of Cost. The POS network may be accessed through the Internet, a POS device, or through the Automated Eligibility Verification System (AEVS).

Internet

The Medi-Cal Web site on the Internet at https://www.medi-cal.ca.gov/Eligibility/Login.asp allows providers to verify beneficiary eligibility and clear Share of Cost liability. An EVC number on the Internet eligibility response verifies that an inquiry was received and eligibility information was transmitted. This response should be printed and kept in the recipient's file.

Providers who check eligibility via AEVS over the phone do not automatically have access to check eligibility through Medi-Cal's web site. Providers who wish to use the Medi-Cal POS or Medi-Cal web site applications are required to have a Medi-Cal Point of Service (POS) Network/Internet Agreement on file with Denti-Cal.

Questions regarding this form or the Medi-Cal web site should be directed to EDS POS/ Internet Help Desk at (800) 427-1295.

POS Device

An EVC number on a printout from the POS device verifies that an inquiry was received and eligibility information was transmitted. This printout should be kept in a recipient's file. The POS Device User Guide contains information about how to use a POS device. This guide can be accessed via the Medi-Cal Web site at:

http://files.medi-cal.ca.gov/pubsdoco/pos_home.asp

Note: Information about obtaining a POS device is available from the POS/Internet Help Desk at (800) 427-1295.

Automated Eligibility Verification System (AEVS)

An Eligibility Verification Confirmation (EVC) number verifies that an inquiry was received and eligibility information was transmitted. (Refer to http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp for information about using telephone AEVS.)

The table below show the alphabetic code listings codes for entering alphabetic data:

Letter	2 Digit Code	Letter	2 Digit Code
A	*21	N	*62
B	*22	0	*63
c	*23	p	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	s	*73
G	*41	T	*81
H	*42	u	*82
I	*43	v	*83
J	*51	w	*91
K	*52	x	*92
L	*53	y	*93
M	*61	z	*12

Share of Cost (SOC)

If the Medi-Cal eligibility verification system indicates a beneficiary has a Share of Cost (SOC), the SOC must be met before a beneficiary is eligible for Medi-Cal benefits. Refer to the applicable transaction manual for directions on applying SOC.

SOC was developed by the Department to ensure an individual or family meets a predetermined financial obligation for medical and dental services before receiving Medi-Cal benefits. Prior authorization requirements are not waived for SOC beneficiaries. The SOC obligation is incurred each month and, consequently, the amount of obligation may vary from month to month. The dollar amount to be applied to any health care cost incurred during that month is computed in order to meet the SOC. Health care costs could be dental, medical, pharmaceutical, hospital, etc. Beneficiaries may use non-Medi-Cal covered services in meeting the monthly SOC obligation.

Providers can determine a beneficiary's SOC when verifying the beneficiary's eligibility through AEVS or by referring to the beneficiary's SOC Case Summary letter. AEVS will report if a beneficiary has an unmet SOC before providing an EVC. Providers may collect payment on the date that services are rendered, or they may allow a beneficiary to pay for the services at a later date or through an installment arrangement. SOC obligations are between the beneficiary and the provider and they should be in writing and signed by both parties.

The Medi-Cal SOC obligation can apply to an individual or family as a whole. Family members who are not eligible for Medi-Cal may be included in the beneficiary's SOC. The health care costs for these ineligible family members can be used to meet the SOC obligation for family members who are eligible. Ineligible family members who are able to do this are identified by an "IE" or "00" aid code on the beneficiary's SOC letter.

Natural or adoptive parents (coded as Responsible Relative (RR) on their child's SOC form) may choose to apply their medical expenses towards their own SOC or towards their child's SOC. In this instance, parents' expenses can be listed fully towards their own SOC or applied partially towards their SOC and any of their children's SOC. However, the total amount reported for a single medical expense cannot be more than the original bill.

An example of this situation would be a family that consists of a stepfather, his wife and his wife's separate child. The wife and her husband are listed

as eligible recipients on the same SOC letter with a $100 SOC. The wife's separate child is listed on a different SOC letter with a $125 SOC. The wife is also listed on her child's SOC letter with an "RR" code in the aid code field.

The wife has expenses that total $75 and that have not been billed to Medi- Cal. She may do one of the following:

1. Apply the entire $75 to her own $100 SOC.
2. Apply the entire $75 to her own child's $125 SOC.
3. Apply any amount less than $75 to her SOC and the balance of the $75 to her child's SOC. The total amount reported cannot exceed the original $75.

Providers should submit a SOC clearance transaction immediately upon receiving payment from the beneficiary. The SOC clearance transaction can be performed by entering the amount through AEVS. Once this amount has been entered, eligibility can be established for that month for the family members eligible for Medi-Cal. If the beneficiary's SOC obligation has been met, providers are entitled to bill Denti-Cal for those services that have been partially paid for by the beneficiary and all other services not paid for by the beneficiary. However, total payments from the beneficiary and Denti-Cal will not exceed the Schedule of Maximum Allowances (SMA).

Interactive Voice Response (IVR) System

The Denti-Cal Interactive Voice Response (IVR) System is a touch-tone only system providing general program information. General program information is available 24 hours a day, seven days a week on the IVR system. To by-pass the entire response, press the required key.

Patient history, claim/TAR status and financial information can be accessed using the IVR system, seven days a week, 2:00 a.m. to 12:00 midnight, with little or no wait time.

Note: Beneficiary aid code status is only accessible by speaking with a Customer Service Representative by calling (800) 322-6384, Monday through Friday, between 8:00 a.m. and 5:00 p.m. (the best time is between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m.).

To access the IVR, enter the star key (*) followed by the provider's NPI.

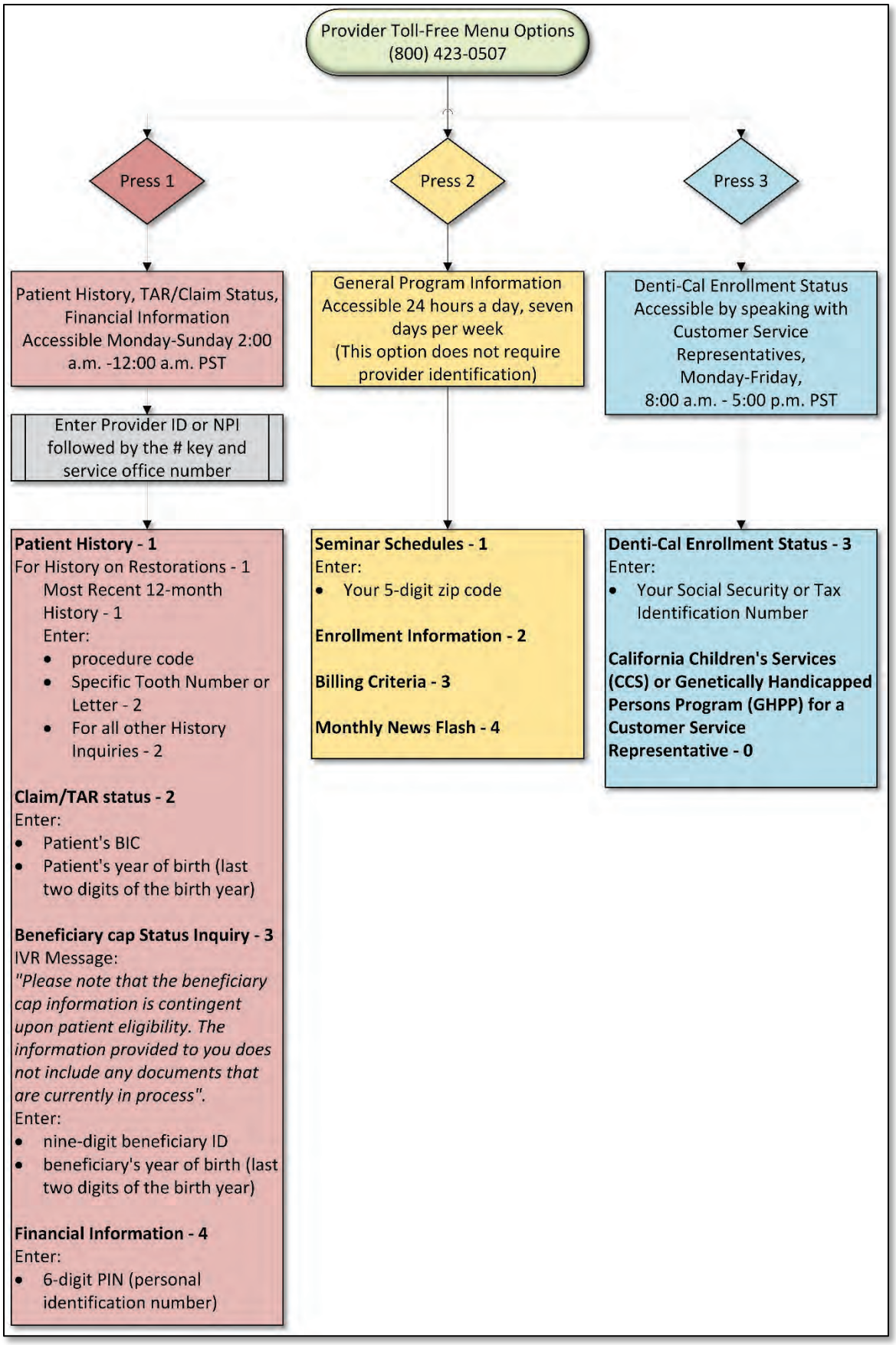
The IVR allows providers to check history and billing criteria.

Patient history information can be obtained by entering the NPI followed by the pound (#) key and entering the current Denti-Cal service office number. Then press "1" from the main menu and enter the provider identification (ID) number. If the provider ID number starts with "B," press the star (*) key, then the number "2," and the number "2" again, followed by the five numbers of your assigned provider number. If the provider number starts with "G" press the star (*) key, then the number "4," followed by the number "1," followed by the five numbers of your assigned provider number. Begin entering patient information by pressing "1" again, then follow the prompts. This option in the IVR gives history on radiographs, prophylaxes, dentures, and many other procedures.

Providers may verify the available balance of a beneficiary's dental cap. For information regarding beneficiary cap status, press 1, then press 3, and follow the prompts. Providers are reminded that beneficiary cap information is contingent upon patient eligibility and does not include any documents currently in process.

Providers may request by FAX: the Schedule of Maximum Allowances (SMA) and the clinical screening dentist application. In addition to details regarding basic and advanced seminars, providers may now get information on orthodontic seminars and workshops.

Note: To check beneficiary eligibility, continue to use AEVS: (800) 456-2387.


Provider Toll-Free Menu Options
(800) 423-0507
Press 1
Press 2
Press 3
Patient History, TAR/Claim Status, Financial Information Accessible Monday-Sunday 2:00 a.m. -12:00 a.m. PST
General Program Information Accessible 24 hours a day, seven days per week (This option does not require provider identification)
Denti-Cal Enrollment Status Accessible by speaking with Customer Service Representatives, Monday-Friday, 8:00 a.m. - 5:00 p.m. PST
Enter Provider ID or NPI followed by the # key and service office number
Patient History - 1
For History on Restorations - 1
Most Recent 12-month History - 1
Enter:
• procedure code
• Specific Tooth Number or Letter - 2
• For all other History Inquiries - 2
Claim/TAR status - 2
Enter:
• Patient's BIC
• Patient's year of birth (last two digits of the birth year)
Beneficiary cap Status Inquiry - 3
IVR Message:
"Please note that the beneficiary cap information is contingent upon patient eligibility. The information provided to you does not include any documents that are currently in process".
Enter:
• nine-digit beneficiary ID
• beneficiary's year of birth (last two digits of the birth year)
Financial Information - 4
Enter:
• 6-digit PIN (personal identification number)
Seminar Schedules - 1
Enter:
• Your 5-digit zip code
Enrollment Information - 2
Billing Criteria - 3
Monthly News Flash - 4
Denti-Cal Enrollment Status - 3
Enter:
• Your Social Security or Tax Identification Number
California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) for a Customer Service Representative - 0

Beneficiary Coverage

Elimination of Optional Adult Dental Services

Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) added Section 14131.10 to the Welfare and Institutions Code, which eliminated specific optional benefits from the Medi-Cal program, including most adult dental services.

Dental services for adults ages 21 and older will no longer be payable under the Denti-Cal program with the following exceptions:

- Federally Required Adult Dental Services (FRADS) - Federal law requires the provision of services by a dentist which a physician could reasonably provide (please refer to Table 1 below for a list of allowable procedure codes).
- Dental services for pregnant beneficiaries for treatment of conditions that might complicate the pregnancy including 60 days post partum.
- Dental services that are necessary as either a condition precedent to other medical treatment or in order to undergo a medical surgery.
- Dental services for beneficiaries who reside in a licensed Skilled Nursing Facility (SNF) or licensed Intermediate Care Facility (ICF). Refer to "Section 2: Program Overview" for more information.

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes are reimbursable for beneficiaries 21 years of age and older:

Note: Procedure codes marked with an asterisk (*) are only payable when the procedure is appropriately rendered in conjunction with another FRADS or pregnancy related procedure.

D0250*, D0260*, D0290*, D0310*, D0320*, D0322*, D0502, D0999, D2910, D2920, D2940, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5953, D5954, D5955, D5958, D5959, D5960, D5982, D5983, D5984, D5985, D5986, D5987, D5988, D5999, D6092, D6093, D6100, D6930, D6999, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7540, D7451, D7460, D7461, D7465, D7490, D7510, D7511, D7520, D7521, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7680, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7780, D7810, D7820, D7830, D7840, D7850, D7852, D7854, D7856, D7858, D7860, D7865, D7870, D7872, D7873, D7874, D7875, D7876, D7877, D7910, D7911, D7912, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7955, D7971, D7980, D7981, D7982, D7983, D7990, D7991, D7995, D7997, D7999, D9110, D9210, D9220, D9221, D9230, D9241, D9242, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9930, D9999.

Table 3: Restored Adult Dental Services (RADS)

Effective May 1, 2014 some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82).

D0150, D0210, D0220, D0230, D0270, D0272, D0274, D0330, D0350, D1110, D1206, D1208, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932, D2933, D2952, D2954, D3310, D3346, D5110, D5120, D5130, D5140, D5410, D5411, D5510, D5520, D5610, D5730, D5731, D5750, D5751, D5850, D5851, D5860

Dental Treatment Precedent to a Covered Medical Procedure

Dental services that are necessary as either a condition precedent to other medical treatment or in order to undergo a medical surgery.

Beneficiaries may receive dental services that are necessary in order to undergo a covered medical service. A precedent dental service is one that is medically necessary in order for a medical procedure to subsequently be performed. Virtually all precedent dental services are for the improvement or elimination of transient bacteremia (the presence of bacteria in the bloodstream of the patient). One example is when a patient is scheduled for a heart transplant, and oral infections need to be eliminated prior to the surgery. For many of these cases, the extraction of infected teeth is the most prevalent and

effective treatment. Tooth extractions are covered by the Denti-Cal Program under FRADS (see Table 1), and do not require a Treatment Authorization Request (TAR).

When providers request treatment other than extractions or other FRADS procedures that do not require prior authorization, they must submit a TAR for those services. Necessary diagnostic radiographs/photographs and exams, however, may be done without prior authorization when they are included on the same TAR as the treatment requested. Providers should submit the following documentation with their TAR; all required radiographs/photographs for the specific procedure(s) requested, as well as all required written documentation and/or forms. In addition, providers must submit a letter from the patient's physician that details the specific medical procedure(s) that are to be performed. This statement must be on the physician's or implant center's professional letterhead and must be signed and dated by the physician.

TARs for dental treatment precedent to a medical procedure will be subject to special handling. Please call the Telephone Service Center at (800) 423-0507 for special instructions regarding the submission of these requests. Do not send these TARs to the regular Denti-Cal P.O.Box as they may be denied.

$1,800 Limit per Calendar Year for Beneficiary Dental Services

The fiscal year (FY) 2005-2006 Budget Act required the Department to employ changes in covered benefits as set forth in Assembly Bill 131 (Chapter 80, Statutes of 2005). Assembly Bill 131 amends Section 14080 of the Welfare and Institutions Code by limiting non-exempt dental services for beneficiaries 21 years of age or older to $1,800 per beneficiary for each calendar year.

Providers are responsible for checking the beneficiary dental cap status prior to rendering services to determine the current remaining balance. This information can be accessed by telephoning Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should:

- verify the beneficiary's dental cap.
- discuss with the beneficiary any other treatment recently received from another provider.
- quickly submit claims for procedures not requiring prior authorization.
- upon receipt of a NOA, promptly perform services and submit requests for payment.

Providers are reminded that approval of a TAR does not guarantee payment. Debits toward the dental cap are based upon the order in which claims and NOAs are processed. Non-exempt services will be paid in the order they are received and processed until the annual dental cap is reached for a calendar year.

Providers may not bill beneficiaries when the program has paid any amount on a specific procedure as the result of the dental cap being met. This partial payment on a procedure must be considered payment in full.

Providers may only bill beneficiaries their usual, customary, and reasonable fees if the $1,800 limit per calendar year for dental services (dental cap) has been met and nothing has been paid on a procedure.

Payments will not be applied towards the $1,800 per calendar year limit for any of the following:

1. Emergency dental services.
2. Services that are federally mandated, including pregnancy-related services.
3. Dentures.
4. Maxillofacial and complex oral surgery.
5. Maxillofacial services, including dental implants and implant-retained prostheses.
6. Services provided in long-term care facilities.

Table 5: Exempt Dental Services

The following procedures have been identified as always exempt from the dental cap limitation. Those procedures are D0502, D2910, D2920, D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5410, D5411, D5421, D5422, D5660, D5730, D5731, D5740, D5741, D5850, D5851, D5860, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5951, D5953, D5954, D5955, D5958, D5959, D5960, D5999, D6010, D6040, D6050, D6053, D6054, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6078, D6079, D6080, D6090, D6091, D6092, D6093, D6094, D6095, D6100, D6194, D6199, D6930, D6980, D6999, D7260, D7270, D7285, D7286, D7440, D7441, D7450, D7451, D7460, D7461, D7490, D7510, D7511, D7520, D7521, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7810, D7820, D7830, D7840, D7850, D7852, D7854, D7856, D7858, D7860, D7865, D7870, D7872, D7873, D7874, D7875, D7876, D7877, D7910, D7911, D7912, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7955, D7980, D7983, D7991, D7995, and D7999.

Table 6: Exempt Emergency Dental Services

The following procedure codes may be exempt from the dental cap limitation if they are related to an adequately documented emergency service: D0160, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0330, D0999, D1550, D2940, D2970, D3220, D3221, D3240, D3999, D4920, D4999, D5510, D5520, D5610, D5620, D5630, D5640, D5650, D6100, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7261, D7411, D7412, D7413, D7414, D7415, D7465, D7530, D7680, D7780, D7946, D7947, D7948, D7949, D7970, D7971, D7990, D8691, D9110, D9120, D9210, D9220, D9221, D9230, D9241, D9242, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9930, D9999.

Pregnancy-Related Services

Effective October 1, 2014, pregnant beneficiaries, regardless of age, aid code, and/or scope of benefits will be eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program so long as all MOC procedure requirements and criteria are met. Beneficiaries will also be eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th day falls.

If you receive a denial (Adjudication Reason Code 503A or 503B) 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.

Radiograph Requirements for Pregnant and Postpartum Beneficiaries

For all procedures that require radiographs/prior authorization, no payment will be made if the radiographs are not submitted. "Patient refused x-rays" will not be acceptable documentation for non-submission of radiographs. Additional information regarding dental care during pregnancy can be found at the CDA Foundation web site at http://www.cdafoundation.org/learn/education-training/perinatal-oral-health-education.

Long-Term Care

Beneficiaries will be excluded from the dental cap if they have Long Term Care (LTC) aid codes or reside in either Place of Service 4/SNF (Skilled Nursing Facility) or Place of Service 5/ICF (Intermediate Care Facility). Exempt long term aid codes include 13, 23, 53, and 63 (for more information on Aid Codes, refer to the end of this section). Descriptions of these and other aid codes are found in the following pages of this section.

All other aid codes and procedure codes will be subject to the $1,800 calendar year limitation.

Special Needs Patients

Special needs patients are defined as those patients who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform an examination.

Patients may be classified as special needs when a provider has adequately documented the specific condition and the reasons why an examination and treatment cannot be performed without general or intravenous sedation.

Prior authorization is not required for treatment (with the exception of fixed partial dentures, removable prosthetics and implants) in order to minimize the risks associated with sedation.

When treatment is performed without prior authorization (on a procedure that normally would require prior authorization), requests for payment must be accompanied by documentation to adequately demonstrate the medical necessity. Refer to the individual procedures for specific requirements and limitations in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

American Sign Language (ASL) Translation Services

American Sign Language translation services are available to Denti-Cal beneficiaries. To request an ASL translator be present at the time of the appointment, either the provider or the beneficiary must contact Denti-Cal and provide the following information:

- Date of dental appointment
- Start and end time of appointment
- Appointment type (dental, surgical, consult, etc.)
- Name of person needing ASL services
- Office address
- Office contact
- Office phone number

To schedule an ASL translator, providers can call the Provider Customer Service Line at 1-800-423-0507. Beneficiaries can call the Free Beneficiary Customer Service Line at 1-800-322-6384.

Treating Beneficiaries That Reside in Other Counties

Enrolled Denti-Cal providers can treat any eligible beneficiary in the Denti-Cal program no matter where the beneficiary resides. Denti-Cal providers can provide services to eligible beneficiaries that reside in other counties in addition to the county the provider is located. To check Medi-Cal eligibility of a beneficiary, please call the Automated Eligibility Verification System (AEVS) at (800) 456-2387.

Teledentistry

The Department of Health Care Services has opted to permit the use of teledentistry as an alternative modality for the provision of select dental services. Therefore, enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

The goal of teledentistry is to:

- Allow Medi-Cal providers to practice "teledentistry", as defined to mean the transmission of medical information to be reviewed at a later time by a licensed dental provider at a distant site; and
- Authorize modest scope of practice expansions.

Please note that allied dental professionals, such as Registered Dental Hygienists in Alternative Practice, shall not be permitted to bill for services rendered via teledentistry.

Transmission Types

Asynchronous Store and Forward

Asynchronous store and forward is the transmission of a beneficiary's dental information from a site where a beneficiary is located at the time dental services are provided via a telecommunications system or where the asynchronous store and forward service originates (i.e. "originating site") to a provider at a distant site, where the provider reviews the information-within 48 hours-without the beneficiary being present.

A beneficiary receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of

the consultation or within 30 days of the original consultation.

Synchronous or Live Transmissions

Synchronous interaction, or live transmission, is a real-time interaction between a beneficiary and a provider located at a distant site. Live transmissions are limited to 90 minutes per beneficiary per provider, per day. Please note: Live transmissions are only to be used at the beneficiary's request.

Billing for Teledentistry

Billing for Asynchronous Store and Forward (D0999)

Teledentistry claims are identified using Current Dental Terminology (CDT) code D0999 ("Unspecified diagnostic procedure, by report") with a date of service on or after July 1, 2015. The Schedule of Maximum Allowance (SMA) for D0999 used for teledentistry is $0.00.

The following CDT codes may be billed as part of teledentistry by enrolled Denti-Cal billing providers:

- D0120: Periodic oral evaluation — established patient
- D0150: Comprehensive oral evaluation – new or established patient
- D0210: Intraoral — complete series of radiographic images
- D0220: Intraoral — periapical first radiographic image
- D0230: Intraoral — periapical each additional radiographic image
- D0240: Intraoral — occlusal radiographic image
- D0270: Bitewing — single radiographic image
- D0272: Bitewings — two radiographic images
- D0274: Bitewings — four radiographic images
- D0330: Panoramic radiographic image
- D0350: Oral/Facial photographic images

Providers may bill for teledentistry on the same claim form as other types of procedure codes unless they are in conflict with the Denti-Cal Manual of Criteria (MOC).

A claim service line containing procedure D0999, and a date of service on or after July 1, 2015, will be paid $0.00. If a claim containing procedure D0999 is not for teledentistry but for an unspecified diagnostic procedure then Denti-Cal will re-evaluate the claim and modify it to an appropriate CDT procedure code to be paid according to the SMA. If a provider receives $0.00 for Procedure D0999 and the procedure is not for teledentistry then the provider must submit a CIF for the claim explaining the procedure is not for teledentistry. Providers must also include any documentation and/or information as specified in the MOC for D0999.

Billing for Synchronous or Live Transmissions (D9999)

Providers may use CDT Code D9999 for reimbursement of live transmission costs associated with teledentistry (D0999). When submitting a claim for reimbursement of live transmission costs, CDT Code D9999 will only be payable when CDT Code D0999 has been rendered. Transmission costs associated with store and forward are not reimbursable.

The reimbursed rate is 24 cents per minute, up to a maximum of 90 minutes. Procedure D9999 may only be used once per date of service per beneficiary, per provider. Written documentation is required and must include the number of minutes the transmission occurred.

Live transmissions are only billable at the beneficiary's request. If the live transmission cannot occur at the precise time of the beneficiary request, then a subsequent agreed upon time may be scheduled between the beneficiary and provider within a 30 day time period.

Copayment Requirements for Denti-Cal Services

It is the provider's responsibility to determine if a copayment is required according to the Denti-Cal criteria. The copayment, if applicable, should be collected by the provider at the time the dental services are performed. Even though the copayment may be required, the provider has the option of collecting or not collecting the copayment amount.

Copayment amounts are in addition to the usual Denti-Cal provider reimbursement. No deduction will be made from the amounts otherwise approved by Denti-Cal for payment to the provider.

A provider is prohibited by law from denying dental services if a beneficiary cannot make the copayment. The beneficiary is, however, liable to the provider for any copayment amount owed. See Welfare and Institutions Code, Section 14134.

For questions regarding these copayment provisions as they apply to dental services, please contact Denti-Cal toll-free at (800) 423-0507.

MEDI-CAL COPAYMENT CRITERIA		
SERVICES SUBJECT TO COPAYMENT	**COPAYMENT FEE**	**EXCEPTIONS TO FEE**
NON-EMERGENCY SERVICES PROVIDED IN AN EMERGENCY ROOM: A non-emergency service is defined as "any service not required for alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death." Such services provided in an emergency room are subject to copayment.	$5.00	1. Persons aged 18 or under. 2. Any woman receiving perinatal care (services pregnancy and one month following delivery). 3. Persons who are inpatients in a health facility (hospital, skilled nursing facility or intermediate care facility). 4. Any child in AFDC-foster care. 5. Any service for which the program's payment is $10 or less.
OUTPATIENT SERVICES: Physician, optometric, chiropractic, psychology, speech therapy, audiology, acupuncture, occupational therapy, pediatric, surgical center, hospital or clinic outpatient, physical therapy and dental.	$1.00	
DRUG PRESCRIPTIONS: Each drug prescription or refill.	$1.00	All listed above, plus person aged 65 or older.

Emergency Services

Title 22, CCR, Section 51056, states as follows:

(a) Except as provided in subsection (b), "emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(b) For purposes of providing treatment of an emergency medical condition to otherwise eligible aliens pursuant to Welfare and Institutions Code Section 14007.5(d), "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c)Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

(1) Any service classified as an emergency, which would have been subject to prior authorization had it not been so classified, must be supported by a physician's, podiatrist's or dentist's statement which describes the nature of the emergency including relevant clinical information about the patient's condition, and states why the emergency services rendered were considered to be immediately necessary. A mere statement that an emergency existed is not sufficient. It must be comprehensive enough to support a finding that an emergency existed. Such statement shall be signed by a physician, podiatrist or dentist who had direct knowledge of the emergency described in this statement.

(2) The Department may impose post service prepayment audit as set forth in Section 51159(b), to review the medical necessity of emergency services provided to beneficiaries. The Department may require providers to follow the procedures for obtaining authorization on a retroactive basis as the process for imposing post-service prepayment audits. Requests for retroactive authorization of emergency services must adequately document the medial necessity of the services and must justify why the services needed to be rendered on an emergency basis.

(d) Program limitation set forth in Section 51304 and 51310 are not altered by this section.

Within the scope of dental benefits under the program, emergency services may comprise of those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Examples of emergency conditions may include, but are not limited to, the following:

- High risk-to-life or seriously disabling conditions, such as cellulitis, oral hemorrhage, and traumatic conditions.
- Low risk-to-life or minimally disabling conditions, such as painful low grade oral-dental infections, near pulpal exposures, fractured teeth or dentures, where theses conditions are exacerbated by psychiatric or other neurotic states of the patient.

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

OBRA beneficiaries are newly legalized amnesty aliens and/or undocumented aliens who are otherwise eligible for Medi-Cal benefits but are not permanent U.S. residents. These beneficiaries have limited benefits and are only eligible for emergency dental services; they can be identified by their limited scope aid code.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part.

The emergency must be certified in accordance with Section 51056 of Title 22, CCR.

Please note that TARs are not allowed and may not be submitted for these beneficiaries. If a TAR is submitted for any of the procedures described below, it will be denied.

The following are identified as emergency dental procedures for OBRA beneficiaries: D0220, D0230, D0250, D0260, D0290, D0330, D0502, D0999, D2920, D2940, D2970, D3220, D3221, D6092, D6093, D6930, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7490, D7510, D7511, D7520, D7521, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7810, D7820, D7830, D7910, D7911, D7912, D7980, D7983, D7990, D9110, D9210, D9220, D9221, D9230, D9241, D9242, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9930.

When applicable, necessary documentation and/or radiographs to justify the emergency procedure must be submitted with the claim.

When the procedures listed above are provided, an emergency certification statement is always required. This statement must be either entered in the "Comments" area (Field 34) on the claim form or attached to the claim. It must:

1. Describe the nature of the emergency, including clinical information pertinent to the patient's condition; and
2. Explain why the emergency services provided were considered immediately necessary.
3. 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 an emergency existed or that the patient was in pain is insufficient.

Other Health Coverage

The Denti-Cal program follows the regulations in California Code of Regulations (CCR), Title 22, which require full utilization of benefits from all other carriers first. This means Denti-Cal is considered the secondary carrier and can only pay up to the maximum amount allowed for covered benefits. Denti-Cal will make payment only if the primary carrier pays less than the maximum Denti-Cal allowance.

After billing the other coverage carrier, providers should submit a claim to Denti-Cal along with the Explanation of Benefits/Remittance Advice (EOB/RA), Proof of Denial letter, or fee schedule from the other insurance carrier. Denti-Cal will not accept "no other dental coverage" written on the claim, NOA for payment, RTD or CIF. Denti-Cal will apply the coinsurance or deductible to each service in the individual amounts indicated on the EOB/RA and fee schedule; if the other coverage carrier has applied the coinsurance/deductible amount to the claim as a whole, Denti-Cal will distribute the amount equally among all services listed on the claim when calculating payment for covered services. Denti-Cal will pay the difference between the amount the other coverage carrier paid for the service plus the appropriate coinsurance/deductible amount applied to that service, and the Denti-Cal allowed amount for the service.

Note: Insurance information must be submitted for a claim for payment, but is not required for a TAR.

Prepaid Health Plan (PHP)/Health Maintenance Organization (HMO)

When a Medi-Cal beneficiary has a PHP or HMO as other health coverage, he or she must use the plan facilities for regular dental care. Providers should bill the appropriate carrier for out-of-area services or emergency treatment covered by the beneficiary's PHP or HMO.

The following are other health coverage codes:

OHC	Health Coverage Type
9	Healthy Families
A	Pay and Chase
C	CHAMPUS
D	Medicare Part D
F	Medicare HMO
K	Kaiser
L	Dental Only
N	No Other Coverage
P	PHP/HMO
V	Fee-For-Service Carriers

Providers should note that even though the other health coverage code indicates a PHP/HMO, the dental carrier may not be a PHP or HMO.

For Denti-Cal to correctly process claims submitted for payment, a Remittance Advice/Explanation of Benefits (RA/EOB), fee schedule or denial of service letter must accompany the claim to verify the other coverage carrier is a PHP/HMO. Providers billing Denti-Cal for services not included in the beneficiary's PHP/HMO plan must submit an RA/EOB, fee schedule or denial letter showing that the PHP/HMO was billed first.

Child Health and Disability Prevention (CHDP) Gateway

On July 1, 2003, Child Health and Disability Prevention (CHDP) medical providers (not dental providers) began pre-enrolling eligible low-income children under 19 years of age into the new CHDP Gateway. CHDP Gateway providers encourage parents to apply for health care coverage for their children through Medi-Cal or Healthy Families. The children are eligible to receive Full Scope, fee-for-service Medi-Cal and Denti-Cal benefits during the month of application and the following month, or until the processing of their application is complete. Denti-Cal reimbursement rates for children eligible for this temporary coverage are the same as the usual Denti-Cal rates. Children who are not eligible for either program will continue to receive CHDP services in accordance with the CHDP periodicity table.

Since the Gateway began, several issues have arisen that may be of interest to Denti-Cal providers:

- Because some children may be eligible for only 1-2 months, it is very important for

children with temporary Medi-Cal eligibility to be seen as quickly as possible. A number of offices and clinics have responded by setting aside a block of time to see these children.

- Children enrolled through the Gateway will ordinarily receive their BIC ID card within 10 days of enrollment. In the interim, they will have an "immediate eligibility document," which will be either a copy of a printout from an Internet Web site or a Point of Service (POS) device receipt similar to a gas station pump receipt. This document displays the beneficiary's BIC ID number and is an acceptable form of identification that should be accepted until the BIC ID card is received. Regardless of whether the beneficiary presents a BIC ID card or a paper immediate eligibility document, all providers, including Children's Treatment Program (CTP) providers, must always check a beneficiary's eligibility status at each visit. The PM160 form is insufficient documentation for participation in the CHDP Gateway.
- The immediate eligibility document can contain several different responses, so it is important to read the response carefully. All providers participating in the CHDP Gateway, including CTP providers, must check eligibility for every beneficiary at every visit, regardless of what the response says. The PM160 form is insufficient.
- Children who are determined ineligible for temporary Medi-Cal coverage through the Gateway may be assigned other emergency or pregnancy-related Medi-Cal aid codes. If a child switches dentists because they were unable to complete treatment prior to termination of their temporary Medi-Cal coverage, Denti-Cal encourages the child's provider to provide the child's treatment plan and radiographs to their new dentist to prevent unnecessary duplication of costs.
- Because of the short period of eligibility for some children, Denti-Cal encourages providers to allow their names and phone numbers to be distributed to CHDP medical providers. Providers willing to do this should call the local CHDP office to be included on a referral list. Access the local CHDP office at http://ww2.dhcs.ca.gov/services/chdp/Pages/default.aspx. Also, if Denti-Cal providers are able to accommodate children eligible for the Gateway on short notice, notify the CHDP medical providers so they will know of your willingness to see these children relatively quickly. (For additional eligibility procedures for CHDP visit the following web site: http://files.medi-cal.ca.gov/pubsdoco/publications/Masters-other/verifone/eligtrans_ver00.pdf.)

Altered Cards and Other Abuses of the Denti-Cal Program Fraud, Help Stop:Altered Cards and Other Abuses

The Department is requesting that dental providers be reminded that all beneficiary information is confidential and must be protected from disclosure to unauthorized personnel. Beneficiary identification includes the following:

- Beneficiary's name
- address
- telephone number
- social security number
- Medi-Cal identification number

Protecting confidential information is especially important for providers of inpatient care billing and third-party insurance organizations when utilizing independent billing agencies, as well as employees who appear to be inappropriately accessing such information.

Dental providers should not accept any Medi-Cal identification card that has been altered in any way. If a beneficiary presents a paper or plastic card that is photocopied or contains erasures, strike-outs, white-outs, type-overs, or appears to have been altered in any other way, the provider should request that the beneficiary obtain a new card from his or her county social services office prior to performing services. Health care providers are encouraged to report evidence of fraud to the Attorney General's Medical Fraud Hotline at (800) 722-0432. Any provider who

suspects a beneficiary of abusing the Denti-Cal program may call (800) 822-6222. Situations where abuse of the program may be suspected include:

- Use of another person's Medi-Cal identification card;
- Presenting an altered card;
- Attempting to obtain excessive or inappropriate drugs.

Misuse of Benefits Identification Card

The Department's Medical Review Branch has increased the number of replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. This process may be further escalated as other misuses of BICs are discovered.

If a provider receives a response during the eligibility verification process that states "current BIC ID and issue date required", the provider must ask the beneficiary for his/her new card.

Attaching a copy of the BIC card for documentation purposes will not be accepted.

Prevention of Identity Theft

To prevent identity theft, the Department requires all providers to avoid using a beneficiary's Social Security Number (SSN) whenever possible, and reminds them that SSNs are not permitted on forms submitted for payment. Claims or TARS submitted with SSNs will be denied.

When submitting TAR/Claim forms to Denti-Cal, providers should use the 14-character ID number from the BIC.

Beneficiary Complaint or Grievance Procedures

A Medi-Cal beneficiary with a complaint or grievance concerning scope of benefits, quality of care, modification or denial of a TAR/Claim form, or other aspect of services provided under the Denti-Cal Program must direct the complaint or grievance as follows:

Initial Appeal to Provider

The beneficiary should initiate action by submitting the complaint or grievance to the provider, identifying the complaint or grievance by specifically describing the disputed service, action, or inaction. The provider responsible for the dental needs of the beneficiary should attempt to resolve the complaint or grievance within the parameters of the Denti-Cal program.

Notification to Denti-Cal

When action at the provider level fails to resolve the complaint or grievance, the beneficiary should telephone Denti-Cal at (800) 322-6384, identify himself/herself and the provider involved, and specifically describe the disputed services, action, or inaction. The beneficiary may also complete the Beneficiary Medi-Cal Dental Program Complaint Form (a sample, found on the following pages, is to be copied for the beneficiary) and return it to Denti-Cal at the address indicated on the form.

Denti-Cal Beneficiary Services will make every effort to resolve the problem at this level. Denti-Cal may refer the beneficiary back to the provider for resolution of the problem, or send the Beneficiary Medi-Cal Dental Program Complaint Form to the beneficiary for completion.

Denti-Cal will acknowledge the written complaint or grievance within five (5) calendar days of receipt. The written complaint or grievance may be referred to a Denti-Cal dental consultant, who will determine the next course of action, which could include contacting the patient and/or provider, referring the patient to a clinical screening examination by a Denti-Cal Clinical Screening Dentist, or referral to the appropriate peer review body.

When a copy of the beneficiary's chart and other pertinent information is requested from a provider's office, it is important that this information be submitted to Denti-Cal within the time frame indicated on the request to avoid potential recoupment of funds previously paid for the service(s) at issue.

Denti-Cal will send a letter summarizing its conclusion and reasons substantiating the decision to the patient within 30 days of the receipt of the complaint or grievance. If it is determined that there is a need to recoup funds for previously paid service(s), Denti-Cal will issue the provider a written notification indicating the specific reasons for the recoupment.

If a beneficiary is not able to make his/her scheduled clinical screening the 30 days may be extended.

If a beneficiary is not satisfied with the decision of the complaint review process, he/she may ask for a State Hearing by writing to or calling:

Office of the Chief Administrative Law Judge
State Department of Social Services
PO Box 13189 Sacramento, CA 95813-3189
Or:
(800) 952-5253

The following three pages include the forms to submit for beneficiary complaints. The 3rd, blank page is for comments relating to the complaint.

Beneficiary Medi-Cal Dental Program Complaint Form (Page 1)

Denti-Cal

California Medi-Cal Dental Program

BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM

Please fill in the form below and describe your questions or complaints completely. This information is important and necessary to research and resolve your questions or complaints.

MEDI-CAL IDENTIFICATION NUMBER: _____

SOCIAL SECURITY NUMBER: XXXXXXXXX _____

TELEPHONE NUMBER: (_____) _____- _____

MESSAGE TELEPHONE NUMBER: (_____)_____

YOUR REPRESENTATIVE (if not yourself):

NAME:_____

ADDRESS: _____

CITY: _____, STATE: _____ ZIP CODE _____

TELEPHONE NUMBER: (_____)_____

YOUR DENTAL PROVIDER"S NAME:_____

ADDRESS:_____

CITY: _____, STATE: _____ ZIP CODE _____

TELEPHONE NUMBER: (_____)_____

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384

Beneficiary Medi-Cal Dental Program Complaint Form (Page 2)

Denti-Cal

California Medi-Cal Dental Program

BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM (Page 2)

TYPE OF COMPLAINT:

_____Dentist service was incomplete or unsatisfactory

_____Clinical Screening process was unsatisfactory

_____Other

_____Comments (Please describe your questions or complaints/ grievances completely here. Use the reverse side of this form or additional pages if you need additional space.)

_____

_____

_____

_____

_____

PLEASE SIGN AND DATE THIS FORM:

It may be necessary to obtain your medical records from your dental care provider. Your signature below authorizes release of your dental records to Denti-Cal.

SIGNATURE_____DATE_____

Return this form to:

Medi-Cal Dental Program
Beneficiary Services Group
P. O. Box 15539
Sacramento, CA 95852-1539

When we receive this information, we will research your questions or complaints/grievances and notify you of our findings. If it is necessary for you to appear for a clinical examination in order to resolve this matter, we will notify you in writing of the date, time, and location of this appointment.

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384

Beneficiary Medi-Cal Dental Program Complaint Form (Blank)

Denti-Cal

California Medi-Cal Dental Program

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384

Grievance and Complaint Procedures to the Department of Managed Health Care

Grievance and complaint procedures for both beneficiaries and providers are maintained in order to resolve or adjudicate differences in professional judgments or opinions, misunderstandings in prior authorization or payment policies, and interpretation of the level and scope of benefits of the Denti-Cal program.

For more information visit the California Department of Managed Health Care (DMHC) Web site: http://www.dmhc.ca.gov/aboutthedmhc/.

The following page contains information on how to file a complaint with the DMHC.

Notice from the Department of Managed Health Care (How to File a Complaint with DMHC)

Denti-Cal

California Medi-Cal Dental Program

Notice from the Department of Managed Health Care

You may file a complaint with the California Department of Managed Health Care after you have completed Delta's grievance process or after you have been involved in Denti-Cal's grievance process for 30 days. You may file a grievance with the Department immediately in an emergency situation that is one involving severe pain and imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at **(1-800-322-6384)** and use your plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384 B-1

State Hearing

According to California Code of Regulations (CCR), Title 22, Section 50951:

Applicants or beneficiaries shall have the right to a State hearing if dissatisfied with any action or inaction of the county department, the Department of Health Services or any person or organization acting in behalf of the county or [t]he Department relating to Medi-Cal eligibility or benefits….

Authorization of Services Through the State Hearing Process

Services can be authorized through the State Hearing process in two ways:

1. A conditional withdrawal; or
2. A granted decision.

Conditional Withdrawal

A conditional withdrawal can be offered to the beneficiary upon receipt of additional information from either the beneficiary or the dentist. If the beneficiary agrees to the conditions of the withdrawal, a pink authorization letter is mailed to him/her. The beneficiary may then take the authorization to the Denti-Cal provider of his/her choice. In order to be paid for services provided, the treating provider is responsible to:

1. Be an enrolled Denti-Cal provider.
2. Verify the patient's eligibility.
3. Provide ONLY the service(s) authorized within the 180 days of the date on the letter.
4. Submit a claim for payment within 60 calendar days from the date of the last completed service provided within the authorization period. The claim must include the original pink authorization letter bearing the original signature. Mail the claim for payment to:

   Denti-Cal
   California Medi-Cal Program
   Attn: State Hearings
   PO Box 13898
   Sacramento, CA 95853

Granted Decision

If an administrative law judge determines a denied service should be authorized, the judge will issue a GRANTED DECISION. Through the action, the beneficiary is authorized to take the decision to the Denti-Cal provider of his/her choice to receive services. In order to be paid for services provided, the treating provider is responsible to:

1. Be an enrolled Denti-Cal provider.
2. Verify the patient's eligibility.
3. Provide ONLY the service(s) authorized in the "ORDER" section of the decision within 180 calendar days of the signed order.
4. Submit a claim for payment within 60 calendar days from the date of the last completed service performed within the authorization period. The claim must include the Granted Decision and should be mailed to the following address:

   Denti-Cal
   California Medi-Cal Program
   Attn: State Hearings
   PO Box 13898
   Sacramento, CA 95853

Contacting Denti-Cal to Postpone or Withdraw a State Hearing

The Department of Social Services (DSS) has implemented a phone number for providers and beneficiaries wishing to postpone or withdraw a State Hearing. The toll free phone number is (855) 266-1157. This number may also be used to make a general inquiry about a State Hearing that has already been filed.

To make an oral request to file a State Hearing, providers and beneficiaries should continue to call DSS toll free at (800) 952-5253.

Aid Codes

The following aid codes identify the types of services for which different Medi-Cal/CMSP/CCS/GHPP beneficiaries are eligible.

More information about OBRA and IRCA aid codes can be found on www.medi-cal.ca.gov > Publications > Provider Manuals > Part 1-Medi-Cal Program and Eligibility > OBRA and IRCA (obra).

Special Indicators: These indicators, which appear in the aid code portion of the county ID number, help Medi-Cal identify the following:

IE Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR Responsible Relative: An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

Aid Code	Benefits	SOC	Program/Description
0A	Full Scope	No	Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	HF services only (no Medi-Cal)	No	Access for Infants and Mothers (AIM) - Infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
0E	Full Scope	No	Medi-Cal Access Prog Preg Women >213% through 322%
0F	Full Scope	No	Five Month transitional food stamp program. This aid code is for households who are terminating their participation in the CalWORKs program without the need to re-establish food stamp eligibility.
0M	Full Scope	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.
0N	Full Scope	No	AE of temporary, Full Scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. No time limit.

Aid Code	Benefits	SOC	Program/Description
0P	Full Scope	No	Full scope, no SOC Medi-Cal only for females 65 years of age and younger who are diagnosed with breast and/or cervical cancer and found in need of treatment; who have no creditable health insurance coverage and who are eligible for the duration of treatment.
0R	Restricted Services	No	Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for all males and females (regardless of age or immigration status). These individuals must have high cost other health coverage cost-sharing insurance (over $750/year), have a diagnosis of breast (payment limited to 18 months) and/or cervical (payment limited to 24 months) cancer, and are found in need of treatment.
0T	Restricted Services	No	Provides payment of 18 months of breast and 24 months of cervical cancer treatment services for all aged males and females who are not eligible under aid codes 0P, 0R, or 0U, regardless of citizenship, that are diagnosed with breast and/or cervical cancer and found in need of treatment. This aid code does not contain anyone with other creditable health insurance, regardless of the amount of coinsurance. Does not cover individuals with expensive creditable insurance or anyone with unsatisfactory immigration status.
0U	Restricted Services	No	Provides services only for females with unsatisfactory immigration status, who are 65 years of age or younger, diagnosed with breast and/or cervical cancer and are found in need of treatment. These individuals are eligible for federal Breast and Cervical Cancer Treatment Program (BCCTP) for emergency services for the duration of the individual's treatment. State-only breast (payment limited to 18 months) and cervical (payment limited to 24 months) cancer services, pregnancy-related services and LTC services. Does not cover individuals with other creditable health insurance.
0V	Limited Scope	No	Provides Emergency, Long Term Care, and Pregnancy-related services, with no share of cost, to individuals no longer eligible for the Breast and Cervical Cancer Treatment Program.
01	Full Scope	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.
02	Full Scope	Y/N	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.
03	Full Scope	No	Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.
04	Full Scope	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC) (non-FFP). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.
05	None	No	SERIOUSLY EMOTIONALLY DISTURBED CHILDREN

Aid Code	Benefits	SOC	Program/Description
07	Full Scope	No	A cash grant program to facilitate the ongoing adoptive placement of hard-to-place NMDs, whose initial AAP payment occurred on or after age 16 and are over age 18 but under age 21, who would require permanent foster care placement without such assistance.
08	Full Scope	No	Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.
09	None	No	FOOD STAMP PROGRAM - PARTICIPANTS
1A	None	No	Aged Cash Assistance Program for Immigrants (CAPI) – Qualified Aliens
1D	Full Scope	No	Aged – In-Home Support Services (IHSS). Covers aged individuals discontinued from the IHSS residual program for reasons other than the loss of Supplemental Security Income/State Supplemental Payment (SSI/SSP) until the county determines their Medi-Cal eligibility.
1E	Full Scope	No	Craig v. Bonta Continued Eligibility for the Aged. Aid Code 1E covers former SSI beneficiaries who are aged (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
1F	None	Yes	PERSONAL CARE SERVICES PROGRAM
1H	Full Scope	No	Federal Poverty Level – Aged (FPL-Aged). Provides Full Scope (no Share of Cost) Medi-Cal to qualified aged individuals/couples.
1U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Aged (Restricted FPL-Aged). Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/couples who do not have satisfactory immigration status.
1X	Full Scope	No	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with no share of cost and with federal financial participation.
1Y	Full Scope	Yes	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with a Share of Cost and with federal financial participation.
10	Full Scope	No	SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.
11	None	No	AID TO THE AGED - SERVICES ONLY
12	None	No	AID TO THE AGED - SPECIAL CIRCUMSTANCES
13	Full Scope	Y/N	Aid to the Aged – LTC (FFP). Covers persons 65 years of age or older who are medically needy and in LTC status.

Aid Code	Benefits	SOC	Program/Description
14	Full Scope	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.
16	Full Scope	No	Aid to the Aged – Pickle Eligibles (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the Lynch v. Rank lawsuit.
17	Full Scope	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required.
18	Full Scope	No	Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.
2A	Full Scope	No	Abandoned Baby Program. Provides Full Scope benefits to children up to three months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2C	No Dental	No	CCHIP 266% - 322%, 0 =< 19
2D	Full Scope	N	BLIND DISCONTINUED IHSS RESIDUAL
2E	Full Scope	No	Craig v. Bonta Continued Eligibility for the Blind. Aid code 2E covers former SSI beneficiaries who are blind (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
2F	None	Yes	PERSONAL CARE SERVICES PROGRAM
2H	Full Scope	No	Blind - Federal Poverty Level - Full
2L	None	N/A	IHSS - PLUS WAIVER
2M	None	N/A	IHSS - PERSONAL SERVICES
2N	None	N/A	IHSS - RESIDUAL
2V	Full Scope	No	TVCAP RMA Medi-Cal NO SOC
2P	Full Scope	No	ARC Program - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who do not qualify for state CalWORKs.
2R	Full Scope	No	ARC Program - Non-Minor Dependent (NMD) - Medi-Cal coverage for foster youth 18 to 21 years of age (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who does not qualify for state CalWORKs.

Aid Code	Benefits	SOC	Program/Description
2S	Full Scope	No	ARC Program - Federal CalWORKs - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for federal CalWORKs.
2T	Full Scope	No	ARC Program - State CalWORKs - Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for state CalWORKs.
2U	Full Scope	No	ARC Program - State CalWORKs NMD - Medi-Cal coverage for foster youth 18 to 21 years of age (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who qualifies for state CalWORKs.
2X	Full Scope	No	LIMITED TERM REINSTATEMENT
20	Full Scope	No	SSI/SSP Aid to the Blind (FFP). A cash assistance program, administered by the SSA, which pays a cash grant to needy blind persons of any age.
21	None	No	AID TO THE BLIND - SERVICES ONLY
22	None	No	AID TO THE BLIND - SPECIAL CIRCUMSTANCES
23	Full Scope	Y/N	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.
24	Full Scope	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.
26	Full Scope	No	Aid to the Blind – Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit. (See Aid Code 16 for definition of Pickle eligibles.)
27	Full Scope	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.
28	Full Scope	No	Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See Aid Code 18 for definition of eligibility for IHSS.)
3A	Full Scope	No	Safety Net - All Other Families, CalWORKs, Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the assistance unit (AU) due to reaching the CalWORKs 60-month time limit without needing a time extender exception.
3C	Full Scope	No	Safety Net - Two-Parent, CalWORKs Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the AU due to reaching the CalWORKs 60-month time limit without meeting a time extender extension.

Aid Code	Benefits	SOC	Program/Description
3D	Full Scope	No	CalWORKs Pending, Medi-Cal Eligible. Provides Medi-Cal coverage for a maximum period of four months to new CalWORKs recipients.
3E	Full Scope	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3F	Full Scope	No	Two Parent Safety Net & Drug/Fleeing Felon Family.
3G	Full Scope	No	AFDC-FG (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent, who does not meet all federal requirements, but State rules require the individual(s) be aided. This population is the same as Aid Code 32, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3H	Full Scope	No	AFDC-FU (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home. This population is the same as Aid Code 33, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3J	None		CalWORKs – Diversion AF
3K	None		CalWORKs – Diversion 2P
3L	Full Scope	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3M	Full Scope	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3N	Full Scope	No	AFDC – Mandatory Coverage Group Section 1931(b) (FFP). Section 1931 requires Medi-Cal be provided to low-income families who meet the requirements of the Aid to Families with Dependent Children (AFDC) State Plan in effect July 16, 1996.
3P	Full Scope	No	AFDC Unemployed Parent (FFP cash) – Aid to families in which a child is deprived because of the unemployment of a parent living in the home and the unemployed parent meets all federal AFDC eligibility requirements. This population is the same as Aid Code 35, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.

Aid Code	Benefits	SOC	Program/Description
3R	Full Scope	No	Aid to Families with Dependent Children (AFDC) – Family Group (FFP) in which the child/children is/are deprived because of the absence, incapacity or death of either parent. This population is the same as Aid Code 30, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3S	None		CA Registered Domestic Partner
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy-related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full Scope	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3V	Restricted to pregnancy and emergency services	No	Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.
3W	Full Scope	No	Temporary Assistance for Needy Families (TANF) -Timed out, mixed case. Recipients who reach the TANF 60-month time limit, remain eligible for CalWORKs and the family includes at least one non-federally eligible recipient.
3X	None		CalWORKs – Diversion 2P – State only
3Y	None		CalWORKs – Diversion 2P – State only
30	Full Scope	No	AFDC-FG (FFP). Provides aid to families with dependent children in a family group in which the child/children is/are deprived because of the absence, incapacity or death of either parent.
31	None	No	AFDC FAMILY GROUP - SERVICES ONLY
32	Full Scope	No	TANF-Timed out. Recipients who have reached their TANF 60-month time limit and remain eligible for CalWORKs.
33	Full Scope	No	AFDC – Unemployed Parent (State-only program) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home.
34	Full Scope	No	AFDC-MN (FFP). Covers families with deprivation of prenatal care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.
35	Full Scope	No	AFDC-U (FFP cash). Provides aid to families in which a child is deprived because of unemployment of a parent living in the home, and the unemployed parent meets all federal AFDC eligibility requirements.

Aid Code	Benefits	SOC	Program/Description
36	Full Scope	No	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.
37	Full Scope	Yes	AFDC-MN (FFP). Covers families with deprivation of prenatal care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.
38	Full Scope	No	Continuing Medi-Cal Eligibility (FFP). Edwards v Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate Notice of Action sent.
39	Full Scope	No	Initial Transitional Medi-Cal (TMC) – Six Months Continuing Eligibility (FFP). Provides coverage to certain clients subsequent to AFDC cash grant discontinuance due to increased earnings, increased hours of employment or loss of the $30 and 1/3 disregard.
4A	Full Scope	No	Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).
4C	Full Scope	No	AFDC-FC Voluntarily Placed (Fed) (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been voluntarily placed in foster care.
4D	None	No	ADAM
4E	Full Scope	No	Hospital PE Former Foster Care Up to age 26.
4F	Full Scope	No	Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.
4G	Full Scope	No	Kin-GAP. State-only program for children in relative placement receiving cash assistance.
4H	Full Scope	No	Foster Care Children in CALWORKS.
4K	Full Scope	No	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.
4L	Full Scope	No	Foster Care Children In 1931(B)
4M	Full Scope	No	Former Foster Care Children (FFCC) 18 through 20 years of age. Provides Full Scope Medi-Cal benefits to former foster care children who were receiving benefits on their 18th birthday in Aid Codes 40, 42, 45, 4C and 5K and who are under 21 years of age.

Aid Code	Benefits	SOC	Program/Description
4N	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for foster care placement, living with an approved CalWORKs relative who is not eligible for Kin-GAP or foster care
4P	None	No	CalWORKs Family Reunification – ALL FAMILIES, provides for the continuance of CalWORKs services to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
4R	None	No	CalWORKs FAMILY REUNIFICATION – TWO PARENT, provides for the continuation of CalWORKs services to two-parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
4S	Full Scope	No	Serves former foster care NMDs over age 18, but under age 21, by moving them from foster care placements to more permanent placement options through the establishment of a relative guardianship that occurred on or after age 16. (Also "includes youth age 18 but under age 21 based on a disability.")
4T	Full Scope	No	IV-E KinGAP Full Scope No SOC to 21 years-old with exceptions
4U	Ful Scope	No	FFCC Optional Coverage Group
4V	Full Scope	Yes	TVCAP RMA Medi-CAL SOC
4W	Full Scope	No	Covers NMDs age 18 but under age 21, eligible for extended KinGAP assistance based on a disability or based on the establishment of the guardianship that occurred on or after age 16. Non-Title IV-E KinGAP must have a full Medicaid eligibility determination.
40	Full Scope	No	AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.
41	None	No	AFDC - FOSTER CARE - SERVICES ONLY
42	Full Scope	No	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.
43	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for state-only foster care placement.
44	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant (FFP) United States Citizen/U.S. National and aliens with satisfactory immigration status including lawful Permanent Resident Aliens/Amnesty Aliens and PRUCOL Aliens. Provides family planning, pregnancy-related and postpartum services for any female if family income is at or below 200 percent of the federal poverty level.
45	Full Scope	No	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.

Aid Code	Benefits	SOC	Program/Description
47	Full Scope	No	Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to 1 year old and continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant – Covers aliens who do not have lawful permanent resident, PRUCOL, or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.
49	Full Scope	No	Covers NMD, age 18 but under age 21, under AB 12 on whose behalf financial assistance is provided for federal foster care placement.
5A	None		EA Seriously Emotionally Disturbed
5C	Full Scope	No	HFP to Medi-Cal Transitional PE-No Premium
5D	Full Scope	No	HFP to Medi-Cal Transitional PE-Premium Payment
5E	Full Scope	No	HF to Medi-Cal PE-No SOC
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers pregnant alien women who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
5J	Restricted Services	No	Beneficiaries, whose linkage has to be redetermined under Senate Bill 87 (SB 87) requirements, are receiving restricted services due to unsatisfactory immigration status, with no SOC, and whose potential new linkage is disability.
5K	Full Scope	No	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.
5R	Restricted Services	Yes	Beneficiaries, whose linkage has to be re-determined under SB 87 requirements, are receiving restricted services with a SOC, and whose potential new linkage is disability.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.
5W	Restricted to pregnancy and emergency services	No	Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
5X	Full Scope	No	Second Year Transitional Medi-Cal (TMC). Provides a second year of Full Scope (no SOC) TMC benefits for citizens and qualified aliens age 19 and older who have received six months of additional Full Scope TMC benefits under aid code 59 and who continue to meet the requirements of additional TMC. (State-only program.)

Aid Code	Benefits	SOC	Program/Description
50	Restricted to CMSP emergency services only	Y/N	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
51	Full Scope	Yes	IRCA ALIENS - FULL SCOPE BENEFITS
52	Limited Scope	Yes	IRCA ALIENS - EMERGENCY BENEFITS
53	Restricted to LTC services only	Y/N	Medically Indigent – LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Nursing Facility Level A or B and meet all other eligibility requirements of medically indigent, with or without SOC.
54	Full Scope	No	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.
55	Restricted to pregnancy and emergency services	No	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color Of Law (PRUCOL). LTC services: State-only funds; emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.
56	Full Scope	Y	IRCA AG WKRS - FULL SCOPE BENEFITS
57	Limited Scope	Yes	IRCA AG WKRS - EMERGENCY BENEFITS
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers aliens who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
59	Full Scope	No	Additional TMC – Additional Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the expiration of the $30 plus 1/3 disregard, increased earnings or hours of employment, but eligible for Medi-Cal only, may receive this extension of TMC.
6A	Full Scope	No	Disabled Adult Child(ren) (DAC)/Blindness (FFP).
6C	Full Scope	No	Disabled Adult Child(ren) (DAC)/Disabled (FFP).
6D	Full Scope	Y/N	Disabled – In-Home Support Services (IHSS). Covers disabled individuals discontinued from the IHSS residual program for reasons other than the loss of Supplemental Security Income/State Supplemental Payment (SSI/SSP) until the county determines their Medi-Cal eligibility.
6E	Full Scope	No	Craig v Bonta Continued Eligibility for the Disabled. Aid code 6E covers former SSI beneficiaries who are disabled (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
6F	None	Yes	PERSONAL CARE SERVICES PROGRAM

Aid Code	Benefits	SOC	Program/Description
6G	Full Scope	No	250 Percent Program Working Disabled. Provides Full Scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.
6H	Full Scope	No	Federal Poverty Level – Disabled (FPL-Disabled) Provides Full Scope (no Share of Cost) Medi-Cal to qualified disabled individuals/couples.
6J	Full Scope	No	Senate Bill (SB) 87 Pending Disability Program. Provides Full Scope, no Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6K	None		CAPI – Non-Qualified Aliens
6M	None		CAPI – Sponsored Aliens
6N	Full Scope	No	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6R) who are appealing their cessation of SSI disability.
6P	Full Scope	No	PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.
6R	Full Scope	Yes	Senate Bill (SB) 87 Pending Disability Program. Provides Full Scope, Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6S	Full Scope	No	State Only – This aid code supplants those that were in Aid Code 65 prior to 8/24/05 - Aid to the Disabled Substantial Gainful Activity/Aged, Blind, Disabled – Medically Needy IHSS (non-FFP). Covers persons who (a) were once determined to be disabled in accordance with the provisions of the SSI/SSP program and were eligible for SSI/SSP but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations. They must also continue to suffer from the physical or mental impairment that was the basis of the disability determination or (b) are aged, blind, or disabled medically needy, and have the costs of IHSS deducted from their monthly income.
6T	None		CAPI – Limited Term Qualified Aliens
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.
6V	Full Scope	No	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.

Aid Code	Benefits	SOC	Program/Description
6W	Full Scope	Yes	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.
6X	Full Scope	No	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
6Y	Full Scope	Yes	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
60	Full Scope	No	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.
61	None	No	AID TO THE DISABLED - SPECIAL CIRCUMSTANCES
62	None	No	DISABLED - LONG TERM CARE
63	Full Scope	Y/N	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.
64	Full Scope	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.
65	Full Scope	Y/N	Katrina – covers eligible evacuees of Hurricane Katrina
66	Full Scope	No	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v Rank lawsuit. No age limit for this aid code.
67	Full Scope	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See Aid Code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.
68	Full Scope	No	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See Aid Codes 18 and 65 for definition of eligibility for IHSS).
7A	Full Scope	No	100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
7C	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/ Nonimmigrant Status/[IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy-related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
7E	Full Scope	No	100% New Entrant Non-Immigrant

Aid Code	Benefits	SOC	Program/Description
7F	Valid for pregnancy verification office visit	No	Presumptive Eligibility (PE) – Pregnancy Verification (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care Services (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive.
7H	Valid only for TB-related outpatient services	No	Medi-Cal Tuberculosis (TB) Program. Covers individuals who are TB-infected for TB-related outpatient services only.
7J	Full Scope	No	Continuous Eligibility for Children (CEC) Program. Provides Full Scope benefits to children up to 19 years of age who would otherwise move to a SOC (Share of Cost).
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC) Program. Provides emergency and pregnancy-related benefits (no SOC) to children up to 19 years of age who would otherwise move to a SOC.
7L	Full Scope	No	ELE 19 through 64 <= 128% FPL - Disabled No Medicare
7M	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors aged 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning.
7N	Valid for Minor Consent services	No	Minor Consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning.
7P	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors age 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning and outpatient mental health treatment.
7R	Valid for Minor Consent services	Y/N	Minor Consent Program (FFP). Covers minors under age 12. Limited to services related to family planning and sexual assault.
7S	Full Scope	No	Cal Fresh Express Lane for Parents Age 19-64, at or below 138% FPL.
7T	Full Scope	No	Free National School Lunch Program (NSLP) Express Enrollment. Children determined by their school, designated as an express enrollment entity, as eligible for express enrollment.
7U	Full Scope	No	Cal Fresh Express Lane for Adults Age 19-64, at or below 130% FPL.
7W	Full Scope	No	Cal Fresh Express Lane Enrollment for Children Age 0-19, at or below 130% FPL.

Aid Code	Benefits	SOC	Program/Description
7X	Full Scope	No	Two months of Healthy Families Program (HFP) Bridge. Provides two calendar months of health care benefits with no SOC to Medi-Cal parents, caretaker relatives, legal guardians, and children who appear to qualify for the Healthy Family Program.
7Y	Full Scope	No	HF to Medi-Cal Bridge (HFP) provides two additional calendar months of HF to adults and children who at the annual review are ineligible for HF and appear to qualify for Medi-Cal.
71	Restricted to dialysis and supplemental dialysis-related services	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP) (Non-FFP). Covers persons of any age who are eligible only for dialysis and related services.
72	Full Scope	No	133 Percent Program. Child-United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
73	Restricted to parenteral hyperalimentation-related expenses	Y/N	Medi-Cal TPN Only Program/Medi-Cal TPN Supplement Program (Non-FFP). Covers persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.
74	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program. Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.
79	Full Scope	No	Asset Waiver Program (Infant). Provides full Medi Cal benefits to infants up to 1 year, and beyond 1 year when inpatient status, which began before first birthday, continues and family income is between 185 percent and 200 percent of the federal poverty level (State-Only Program).
8A	None	No	QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)
8C	None	No	SPECIFIED LOW INCOME MEDI-CAL BENEFICIARY (SLMB)
8D	None	No	QUALIFYING INDIVIDUAL - 1 PROGRAM (QI-1)
8E	Full Scope	No	Children under the age of 19, apparently eligible for any no-cost Medi-Cal program, will receive immediate, temporary, fee-for-service, Full Scope, no-cost Medi-Cal benefits.

Aid Code	Benefits	SOC	Program/Description
8F	CMSP services only (companion aid code)	Y/N	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
8G	Full Scope	No	Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.
8H	Family PACT (SOFP services only). No Medi-Cal	N/A	Family PACT (also known as SOFP – State Only Family Planning). Comprehensive family planning services for low income residents of California with no other source of health care coverage.
8K	None	No	QUALIFYING INDIVIDUAL - 2 PROGRAM (QI-2)
8N	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8P	Full Scope	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides Full Scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8R	Full Scope	No	100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident/ PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides Full Scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
8T	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/Nonimmigrant Status/(IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
8U	Full Scope	No	Deemed Eligibility (DE) CHDP Gateway/Medi-Cal. Provides Full Scope no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.
8V	Full Scope	Yes	Deemed Eligibility (DE) CHDP Gateway/Medi-Cal. Provides Full Scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant's birth and SOC was met.

Aid Code	Benefits	SOC	Program/Description
8W	Full Scope	No	Child Health Disability Program (CHDP) Gateway Medi-Cal – Aid Code 8W provides for the pre-enrollment of children into the Medi-Cal program which will provide temporary, no share of cost (SOC), Full Scope Denti-Cal benefits. Federal Financial Participation (FFP) for these benefits is available through Title XIX of the Social Security Act.
8X	Full Scope	No	CHDP Gateway Healthy Families – Aid Code 8X provides pre-enrollment of children into the Medi-Cal program. Provides temporary, Full Scope Denti-Cal benefits with no SOC until eligibility for the Healthy Families program can be determined. Federal Financial Participation (FFP) for these benefits is available through Title XXI of the Social Security Act.
8Y	CHDP Only	No	CHDP – Aid Code 8Y provides eligibility to the CHDP ONLY program for children who are known to MEDS as not having satisfactory immigration status. There is no Federal Financial Participation for these benefits. This aid code is state funded only.
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.
81	Full Scope	Y/N	MI-Adults Aid Paid Pending (Non-FFP). Aid Paid Pending for persons over 21 but under 65, with or without SOC.
82	Full Scope	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under Aid Code 82 until age 22 if they have filed for a State hearing.
83	Full Scope	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
84	CMSP services only (no Medi-Cal)	No	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
85	CMSP services only (no Medi-Cal)	Yes	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
86	Full Scope	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent.
87	Full Scope	Yes	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	CMSP is administered by Doral Dental Services of California: (800) 341-8478.
89	CMSP services only (no Medi-Cal)	Yes	CMSP is administered by Doral Dental Services of California: (800) 341-8478.

Aid Code	Benefits	SOC	Program/Description
9A	BCEDP only	No	The Breast Cancer Early Detection Program (BCEDP) recipient identifier. BCEDP offers benefits to uninsured and underinsured women, 40 years and older, whose household income is at or below 200 percent of the federal poverty level. BCEDP offers reimbursement for screening, diagnostic and case management services. Please note: BCEDP and Medi-Cal are separate programs, but BCEDP is using the Medi-Cal billing process (with few exceptions).
9C	None	No	EXPANDED ACCESS TO PRIMARY CARE
9D	No Dental	No	CCS Only Child Enrolled in a Health Care Plan
9G	None		General Assistance/General Relief (County Only tracking)
9H	HF services only (no Medi-Cal)	N/A	The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 250 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.
9J	GHPP	No	Genetically Handicapped Person's Program (GHPP)-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	California Children's Services (CCS)-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9M	CCS Medical Therapy Program only	No	Eligible for CCS Medical Therapy Program services only.
9N	CCS Case Management	No	Medi-Cal recipient with CCS-eligible medical condition. Eligible for CCS case management of Medi-Cal benefits.
9R	CCS	No	CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management). The child's county of residence has no cost sharing for the child's CCS services.
9T	Full Scope	No	HF adults linked by a child who is eligible for no Share of Cost Medi-Cal or HF.
9U	CCS	NO	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e. diagnosis, treatment, therapy and case management). The child's county of residence has county cost sharing for the child's CCS services.
9X	None	No	COUNTY ONLY - FOSTER CARE
94	CHDP		CHDP
C1	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged - Medically Needy.

Aid Code	Benefits	SOC	Program/Description
C2	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged - Medically Needy, SOC.
C3	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind - Medically Needy.
C4	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Blind - Medically Needy, SOC.
C5	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC - Medically Needy.
C6	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. AFDC - Medically Needy SOC.
C7	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled - Medically Needy.
C8	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Disabled - Medically Needy, SOC.
C9	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI - Child. Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
D1	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. MI - Child SOC. Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.

Aid Code	Benefits	SOC	Program/Description
D2	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged - Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D3	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Aid to the Aged - Long Term Care (LTC), SOC. Covers persons 65 years of age or older who are medically needy and in LTC status. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D4	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind - Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).

Aid Code	Benefits	SOC	Program/Description
D5	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Blind - Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D6	Restricted to pregnancy and emergency services	No	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled - Long Term Care (LTC). Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D7	Restricted to pregnancy and emergency services	Yes	OBRA Aliens - Not PRUCOL and Unverified Citizens - Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the OBRA and IRCA section in this manual. Disabled - Long Term Care (LTC), SOC. Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).
D8	Restricted to pregnancy and emergency services	No	OBRA Aliens and Unverified Citizens - Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI - Confirmed Pregnancy. Covers persons aged 21 years or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent.

Aid Code	Benefits	SOC	Program/Description
D9	Restricted to pregnancy and emergency services	Yes	OBRA Aliens and Unverified Citizens - Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status and unverified citizens. MI - Confirmed Pregnancy SOC. Covers persons aged 21 or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
E1	Restricted to Pregnancy Related Services	No	MC-HF-Bridge Limited Scope No SOC
E2	Full Scope	No	ACA 2101 (f) Citizen/Lawful Age 0-19 No Premium
E4	Preg/Emerg	No	ACA 2101 (f) Undocumented Age 0-19 No Premium
E5	Full Scope	No	ACA 2101 (f) Citizen/Lawful Age 1-19 With Premium
E6	Full Scope	No	AIM Infants>213% FPL up to and including 266% FPL
E7	Full Scope	No	AIM-Linked Infant>250% to and incl 300% w premium
G0	Full Scope	No	Full Scope no SOC; State medically paroled adults
G1	None	No	Full Scope no SOC; State medically paroled adults
G2	None	No	Medi-Cal No SOC St Juvenile Inmate Undoc Emerg/Preg
G5	None	No	Limited Medi-Cal No SOC County Juvenile Inmate
G6	None	No	Medi-Cal No SOC Cty Juvenile Inmate Undoc Emerg/Preg
G7	None	No	Limited Medi-Cal SOC County Juvenile Inmates
G8	None	No	Medi-Cal No SOC Cnty Juvenile Inmate Undoc Emerg/Preg.
H0	Full Scope	No	Hospital PE 6-19 above 108% up to 266% FPL
H1	Full Scope	No	Medi-Cal Targeted Low Income FPL for Infants
H2	Full Scope	No	Medi-Cal Targeted Low Income FPL Child 1-6 133-150%
H3	Full Scope	No	Medi-Cal Targeted Low Income FPL Child 1-6 150-250% Prem
H4	Full Scope	No	MC Targeted Low Income FPL Child 6-19 100-150%
H5	Full Scope	No	MC Targeted Low Income FPL Child 6-19 150-250% Prem
H6	Full Scope	No	Hospital PE Infants 0-1 over 208% up to 266% FPL
H7	Full Scope	No	Hospital PE Child 1-6, at or below 142% FPL
H8	Full Scope	No	Hospital PE Child 6-19, at or below 108% FPL
H9	Full Scope	No	Hospital PE Child 1-6 above 142-266% FPL
IE	None	No	INELIGIBLE FOR DENTAL BENEFITS

Aid Code	Benefits	SOC	Program/Description
J1	Full Scope	No	Full-scope No SOC County Med Probation/Comp Release
J2	Full Scope	Yes	Full-scope SOC County Medical Probation
J3	Emergency/Pregnancy	No	Restricted no SOC County Medical Probation
J4	Emergency/Pregnancy	Yes	Restricted SOC County Medical Probation
J5	Full Scope	Yes/ No	FS LTC Aged No SOC/SOC County Med Prob/Comp Release
J6	Emergency/Pregnancy	Yes/ No	RS LTC Aged No SOC/SOC County Med Prob/Comp Release
J7	Full Scope	Yes/ No	FS LTC Dsbl No SOC/SOC County Med Prob/Comp Release
J8	Emergency/Pregnancy	Yes/ No	RS LTC Dsbl No SOC/SOC County Med Prob/Comp Release
K1	Full Scope	No	Single Parent Safety Net & Drug/Fleeing Felon Family
L8	Limited	No	T19 Pregnant Woman Wrap > 138% through 213%
L9	Full Scope	No	T 19 Newly Qualified Immigrants Wrap 0% - 138%
L1	Full Scope	No	LIHP/MCE transition to Medi-Cal Age 19-64, at or below 138% FPL
M1	Full Scope	N	Title XIX. Adults ages 19 to 64. Provides full-scope, no-cost Medi-Cal coverage to adults with income up to 138 percent of the FPL.
M2	Preg/Emerg	N	Adult 19 to 65 at or below 138% FPL Citiz/Lawful
M3	Full Scope	N	Parents/Caretaker Relative Citizens under 109% FPL
M4	Preg/Emerg	N	Parents/Caretaker Relative Undoc under 109% FPL
M5	Full Scope	N	Expansion Child 6-19 yrs 108-133% FPL Citizens
M6	Preg/Emerg	N	Expansion Child 6-19 yrs 108-133% FPL Undoc
M7	Full Scope	N	Pregnant Women under 60% FPL Citizen/Lawful
M8	Preg/Emerg	N	Pregnant Women under 60% FPL Undocumented
M9	Preg/Emerg	N	Pregnant Women 60-213% FPL Limited Citiz/Lawful
M0	Preg/Emerg	N	Pregnant Women 60-213% FPL Limited Scope Undoc
N5	Non-Dental	No	Limited Scope Medi-Cal No SOC State Adult Inmate
N6	Non-Dental	No	Restricted Scope Medi-Cal No SOC State Adult Inmate
N7	Non-Dental	No	Limited Scope Medi-Cal No SOC Cty Adult Inmate
N8	Non-Dental	No	Restricted Scope Medi-Cal No SOC Cty Adult Inmate
N9	Full Scope	No	State Inmate LIHP/MCE transition to Medi-Cal

Aid Code	Benefits	SOC	Program/Description
N0	Full Scope	No	County Inmate LIHP/MCE transition to Medi-Cal
P5	Full Scope	N	ACA Child 6-19 Yrs 0-133% FPL Citizen
P6	Preg/Emerg	N	ACA Child 6-19 Yrs 0-133% FPL Undocumented
P7	Full Scope	N	ACA Child 1-6 Yrs 0-133% FPL Citizen
P8	Preg/Emerg	N	ACA Child 1-6 Yrs 0-133% FPL Undocumented
P9	Full Scope	N	ACA Infants 0-1 Yrs 0-200% FPL Citizen
P0	Preg/Emerg	N	ACA Infants 0-1 Yrs 0-200% FPL Undocumented
R1	Full Scope	No	CalWORKs TCVAP Trafficking Victims
R7	Non-Dental	No	WINS-TCF-Non-2-Parent
R8	Non-Dental	No	Work Incentive Nutritional Supplement-TCF2 Parent
R9	Non-Dental	No	Work Incentive Nutritional Supplement-TCFAP
RR	None	No	RESPONSIBLE RELATIVE
T1	Full Scope	N	Medi-Cal TLIC Infant Undoc 201-250% FPL
T2	Full Scope	N	Medi-Cal TLIC Ages 6-19 Citizen 151-250% FPL Prem
T3	Full Scope	N	Medi-Cal TLIC Ages 6-19 Citizen 134-150% FPL
T4	Full Scope	N	Medi-Cal TLIC Ages 1-6 Citizen 151-250% FPL Prem
T5	Full Scope	N	Medi-Cal TLIC Ages 1-6 Citizen 134-150% FPL
T6	Preg/Emerg	N	Medi-Cal TLIC Infant Citizen 201-250% FPL
T7	Preg/Emerg	N	Medi-Cal TLIC Ages 6-19 Undoc 151-250% FPL Prem
T8	Preg/Emerg	N	Medi-Cal TLIC Ages 6-19 Undoc 134-150% FPL
T9	Preg/Emerg	N	Medi-Cal TLIC Ages 1-6 Undoc 151-250% FPL Prem
T0	Preg/Emerg	N	Medi-Cal TLIC Ages 1-6 Undoc 134-150% FPL Prem
X1	Non-Dental	N	Covered CA-Subsidized Coverage (250-400 FPL)
X2	Non-Dental	N	Covered California-Subsidized Cov 100-150 FPL)
X3	Non-Dental	N	Covered CA-Subsidized Coverage 151-200 FPL)
X4	Non-Dental	N	Covered CA-Subsidized Coverage 201-250 FPL)
X5	Non-Dental	N	Covered CA-Cost Sharing Waiver (100-300 FPL)
X6	Non-Dental	N	Covered CA-AI/AN CSR Only No Income Test
X7	Non-Dental	N	Covered CA-Unsubsidized Coverage (Above 400 FPL)
X8	Non-Dental	N	Covered CA-Lawful Present/MC ineligible <100% FPL

Aid Code	Benefits	SOC	Program/Description
X9	Non-Dental	N	Covered CA-Narrow Bridge Program 200% FPL

Section 5 - Manual of Criteria and Schedule of Maximum Allowances

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Manual of Criteria
for
Medi-Cal Authorization
(Dental Services)

State of California
Department of Health Care Services
Medi-Cal Policy Division
1501 Capitol Avenue, Building 171
Sacramento, CA 95814

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Current Dental Terminology 13 (CDT 13) Codes – Preface

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IMPORTANT: Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) added Section 14131.10 to the Welfare and Institutions Code, which eliminated specific optional benefits from the Medi-Cal program, including most dental services for adults ages 21 and older. Effective May 1, 2014 some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82). Unless specifically identified in the Assembly Bill as a change, the criteria contained in this next section, the Manual of Criteria for Medi-Cal Authorization (Dental Services) will remain in effect. Refer to "Section 4: Elimination of Optional Adult Dental Services" to view the list of Table 1: Federally Required Adult Dental Services (FRADS) and Table 3: Restored Adult Dental Services (RADS) for the exemptions that apply.

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Diagnostic General Policies (D0100-D0999)

1. Radiographs (D0210-D0340):
   A) According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.
   B) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.
   C) Radiographs shall be made available for review upon the request of the Department of Health Services or its fiscal intermediary.
   D) Pursuant to Title 22, CCR, Section 51051, dental radiographic laboratories shall not be considered providers under the Medi-Cal Dental Program.
   E) Radiographs shall be considered current as follows:
      i) radiographs for treatment of primary teeth within the last eight months.
      ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.
      iii) radiographs to establish arch integrity within the last 36 months. Arch radiographs are not required for patients under the age of 21.
   F) All radiographs or paper copies of radiographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph was taken, the provider's name, the provider's billing number, the patient's name, and with the tooth/quadrant/area (as applicable) clearly indicated.
   G) Multiple radiographs of four or more shall be mounted. Three or fewer radiographs properly identified (as stated in "e" above) in a coin envelope are acceptable when submitted for prior authorization and/or payment.
   H) Paper copies of multiple radiographs shall be combined on no more than four sheets of paper.
   I) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.
   J) A panoramic radiograph alone is considered non-diagnostic for prior authorization and/or payment of restorative, endodontic, periodontic, removable partial and fixed prosthodontic procedures.
   K) When arch integrity radiographic images are required for a procedure and exposure to radiation should be minimized due to a medical condition, only a periapical radiograph shall be required. Submitted written documentation shall include a statement of the medical condition such as the following:
      i) pregnancy,
      ii) recent application of therapeutic doses of ionizing radiation to the head and neck areas,
      iii) hypoplastic or aplastic anemia.
   L) Prior authorization for procedures other than fixed partial dentures, removable prosthetics and implants is not required when a patient's inability to respond to commands or directions would necessitate sedation or anesthesia in order to accomplish radiographic procedures. However, required radiographs shall be obtained during treatment and shall be submitted for consideration for payment.
2. Photographs (D0350):
   A) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.
   B) Photographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.
3. Prior authorization is not required for examinations, radiographs or photographs.

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Diagnostic Procedures (D0100-D0999)

PROCEDURE D0120
PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. for patients under the age of 21.
   b. once every six months, per provider, or
   c. after six months have elapsed following comprehensive oral evaluation (D0150), same provider.
3. This procedure is not a benefit when provided on the same date of service with procedures:
   a. limited oral evaluation-problem focused (D0140),
   b. comprehensive oral evaluation- new or established patient (D0150),
   c. Detailed and extensive oral evaluation-problem focused, by report (D0160),
   d. re-evaluation- limited, problem focused (established patient; not post-operative visit) (D0170),
   e. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0140
LIMITED ORAL EVALUATION - PROBLEM FOCUSED

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. for patients under the age of 21.
   b. once per patient per provider.
   c. when provided by a Medi-Cal Dental Program certified orthodontist.
3. Submission of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) is not required for payment.
4. The following procedures are not a benefit, for the same rendering provider, when provided on the same date of service with procedure D0140:
   a. periodic oral evaluation (D0120),
   b. comprehensive oral evaluation- new or established patient (D0150),
   c. Detailed and extensive oral evaluation- problem focused, by report (D0160),
   d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170),
   e. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).
5. This examination procedure shall only be billed for the initial orthodontic evaluation with the completion of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form DC016 (06/09).

PROCEDURE D0145
ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER

This procedure can only be billed as periodic oral evaluation-established patient (D0120) or comprehensive oral evaluation-new or established patient (D0150)-and is not payable separately.

PROCEDURE D0150
COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per patient per provider for the initial evaluation.
3. This procedure is not a benefit when provided on the same date of service with procedures:

   a. limited oral evaluation (D0140),
   b. Detailed and extensive oral evaluation-problem focused, by report (D0160),
   c. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170).
4. The following procedures are not a benefit when provided on the same date of service with D0150:
   a. periodic oral evaluation (D0120),
   b. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0160
DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT

1. Written documentation for payment- shall include documentation of findings that supports the existence of one of the following:
   a. Dento-facial anomalies,
   b. complicated perio-prosthetic conditions,
   c. complex temporomandibular dysfunction,
   d. facial pain of unknown origin,
   e. severe systemic diseases requiring multi-disciplinary consultation.
2. A benefit once per patient per provider.
3. The following procedures are not a benefit when provided on the same date of service with D0160:
   a. periodic oral evaluation (D0120),
   b. limited oral evaluation-problem focused (D0140),
   c. comprehensive oral evaluation- new or established patient (D0150),
   d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170),
   e. office visit for observation (during regularly scheduled hours-no other services performed (D9430).

PROCEDURE D0170
RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)

1. Written documentation for payment- shall include an evaluation and diagnosis justifying the medical necessity.
2. A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:
   a. up to six times in a three month period.
   b. up to a maximum of 12 in a 12-month period.
3. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation (D0160).
4. The following procedures are not a benefit when provided on the same date of service with D0170:
   a. periodic oral evaluation (D0120),
   b. limited oral evaluation-problem focused (D0140),
   c. comprehensive oral evaluation-new or established patient (D0150),
   d. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0180
COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT

This procedure can only be billed as comprehensive oral evaluation-new or established patient (D0150)-and is not payable separately.

PROCEDURE D0190
SCREENING OF A PATIENT

This procedure is not a benefit.

PROCEDURE D0191
ASSESSMENT OF A PATIENT

This procedure is not a benefit.

PROCEDURE D0210
INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per provider every 36 months.

3. Not a benefit to the same provider within six months of bitewings (D0272 and D0274).
4. A complete series shall be at least:
   a. ten (10) periapicals (D0230) and bitewings (D0272 or D0274), or
   b. eight (8) periapicals (D0230), two (2) occlusals (D0240) and bitewings (D0272 or D0274), or
   c. a panoramic radiographic image (D0330) plus bitewings (D0272 or D0274) and a minimum of two (2) periapicals (D0230).
5. When multiple radiographs are taken on the same date of service, or if an intraoral-complete series of radiographic images (D0210) has been paid in the last 36 months, the maximum payment shall not exceed the total fee allowed for an intraoral complete series.

PROCEDURE D0220
INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit to a maximum of 20 periapicals in a 12- month period by the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12-month period.
3. This procedure is payable once per provider per date of service. All additional periapicals shall be billed as intraoral-periapical each additional radiographic image (D0230).
4. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral-periapical each additional radiographic image (D0230).

PROCEDURE D0230
INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit to a maximum of 20 periapicals in a 12- month period to the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.
3. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral-periapical each additional radiographic image (D0230).

PROCEDURE D0240
INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit up to a maximum of two in a six-month period per provider.
3. If any radiographic image size other than 2 1/4" x 3" (57mm x 76mm) is used for an intraoral- occlusal radiographic image (D0240), it shall be billed as a intraoral-periapical first radiographic image (D0220) or intraoral-periapical each additional radiographic image (D0230) as applicable.

PROCEDURE D0250
EXTRAORAL - FIRST RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.

PROCEDURE D0260
EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation

demonstrating medical necessity is not required for payment.
2. A benefit up to a maximum of four on the same date of service.

PROCEDURE D0270
BITEWING - SINGLE RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.
3. Not a benefit for a totally edentulous area.

PROCEDURE D0272
BITEWINGS - TWO RADIOGRAPHIC IMAGES

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for a totally edentulous area.

PROCEDURE D0273
BITEWINGS - THREE RADIOGRAPHIC IMAGES

This procedure can only be billed as bitewing- single radiographic image (D0270) and bitewings- two radiographic images (D0272)

PROCEDURE D0274
BITEWINGS - FOUR RADIOGRAPHIC IMAGES

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for patients under the age of 10
   c. for a totally edentulous area.

PROCEDURE D0277
VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES

This procedure can only be billed as bitewings-four radiographic images (D0274). The maximum payment is for four bitewings.

PROCEDURE D0290
POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. for the survey of trauma or pathology.
4. for a maximum of three per date of service.

PROCEDURE D0310
SIALOGRAPHY

Submit radiology report or radiograph(s) for payment.

PROCEDURE D0320
TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. for the survey of trauma or pathology.
   b. for a maximum of three per date of service.

PROCEDURE D0321
OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT

This procedure is not a benefit.

PROCEDURE D0322
TOMOGRAPHIC SURVEY

1. Written documentation for payment-shall include the radiographic findings and diagnosis to justify the medical necessity.
2. The tomographic survey shall be submitted for payment.
3. A benefit twice in a 12-month period per provider.
4. This procedure shall include three radiographic views of the right side and three radiographic views of the left side representing the rest, open and closed positions.

PROCEDURE D0330
PANORAMIC RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a 36-month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery).
3. Not a benefit, for the same provider, on the same date of service as an intraoral-complete series of radiographic images (D0210).
4. This procedure shall be considered part of an intraoral- complete series of radiographic images (D0210) when taken on the same date of service with bitewings (D0272 or D0274) and a minimum of two (2) intraoral-periapicals each additional radiographic image (D0230).

PROCEDURE D0340
CEPHALOMETRIC RADIOGRAPHIC IMAGE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice in a 12-month period per provider.

PROCEDURE D0350
ORAL/FACIAL PHOTOGRAPHIC IMAGES

1. Photographs shall be submitted, with the claim or Treatment Authorization Request (TAR) for the procedure that it supports, for payment.
2. A benefit up to a maximum of four per date of service.
3. Not a benefit when used for patient identification, multiple views of the same area, treatment progress and post-operative photographs.
4. Photographs shall be necessary for the diagnosis and treatment of the specific clinical condition of the patient that is not readily apparent on radiographs.
5. Photographs shall be of diagnostic quality, labeled with the date the photograph was taken, the provider's name, the provider's billing number, the patient's name and with the tooth/quadrant/area (as applicable) clearly indicated.
6. This procedure is included in the fee for pre-orthodontic treatment visit (D8660) and comprehensive orthodontic treatment of the adolescent dentition (D8080) and is not payable separately.

PROCEDURE D0363
CONE BEAM- THREE-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES

This procedure is not a benefit.

PROCEDURE D0364
CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW

This procedure is not a benefit.

PROCEDURE D0365
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE

This procedure is not a benefit.

PROCEDURE D0366
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MAXILLA, WITH OR WITHOUT CRANIUM

This procedure is not a benefit.

PROCEDURE D0367
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS WITH OR WITHOUT CRANIUM

This procedure is not a benefit.

PROCEDURE D0368
CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES

This procedure is not a benefit.

PROCEDURE D0369
MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0370
MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0371
SIALOENDOSCOPY CAPTURE AND INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0380
CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW

This procedure is not a benefit.

PROCEDURE D0381
CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH- MANDIBLE

This procedure is not a benefit.

PROCEDURE D0382
CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH- MAXILLA, WITH OR WITHOUT CRANIUM

This procedure is not a benefit.

PROCEDURE D0383
CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM

This procedure is not a benefit.

PROCEDURE D0384
CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES

This procedure is not a benefit.

PROCEDURE D0385
MAXILLOFACIAL MRI IMAGE CAPTURE

This procedure is not a benefit.

PROCEDURE D0386
MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE

This procedure is not a benefit.

PROCEDURE D0391
INTERPRETATION OF DIAGNOSTIC IMAGE BY A PRACTITIONER NOT ASSOCIATED WITH CAPTURE OF THE IMAGE, INCLUDING REPORT

This procedure is not a benefit.

PROCEDURE D0415
COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY

This procedure is not a benefit.

PROCEDURE D0416
VIRAL CULTURE

This procedure is not a benefit.

PROCEDURE D0417
COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY DIAGNOSTIC TESTING

This procedure is not a benefit.

PROCEDURE D0418
ANALYSIS OF SALIVA SAMPLE

This procedure is not a benefit.

PROCEDURE D0421
GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES

This procedure is not a benefit

PROCEDURE D0425
CARIES SUSCEPTIBILITY TESTS

This procedure is not a benefit.

PROCEDURE D0431
ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES

This procedure is not a benefit.

PROCEDURE D0460
PULP VITALITY TESTS

This procedure is included in the fees for diagnostic, restorative, endodontic and emergency procedures and is not payable separately.

PROCEDURE D0470
PROCEDURE DIAGNOSTIC CASTS

1. Diagnostic casts are for the evaluation of orthodontic benefits only. Unless specifically requested by the Medi-Cal Dental Program, diagnostic casts submitted for other than orthodontic treatment shall be discarded and not reviewed.
2. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send

original casts, as casts will not be returned.

3. A benefit:
   a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).
   b. for patients under the age of 21.
   c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. only when provided by a Medi-Cal Dental Program certified orthodontist.
4. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. Casts shall be cleaned, treated with an approved EPA disinfectant and dried before being placed in a sealed bag for shipping to the Medi-Cal Dental Program.

PROCEDURE D0472
ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0473
ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0474
ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0475
PROCEDURE DECALCIFICATION PROCEDURE

This procedure is not a benefit.

PROCEDURE D0476
SPECIAL STAINS FOR MICROORGANISMS

This procedure is not a benefit.

PROCEDURE D0477
SPECIAL STAINS, NOT FOR MICROORGANISMS

This procedure is not a benefit.

PROCEDURE D0478
IMMUNOHISTOCHEMICAL STAINS

This procedure is not a benefit.

PROCEDURE D0479
TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0480
ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0481
ELECTRON MICROSCOPY

This procedure is not a benefit.

PROCEDURE D0482
PROCEDURE DIRECT IMMUNOFLUORESCENCE

This procedure is not a benefit.

PROCEDURE D0483
INDIRECT IMMUNOFLUORESCENCE

This procedure is not a benefit.

PROCEDURE D0484
CONSULTATION ON SLIDES PREPARED ELSEWHERE

This procedure is not a benefit.

PROCEDURE D0485
CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE

This procedure is not a benefit.

PROCEDURE D0486

ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0502

OTHER ORAL PATHOLOGY PROCEDURES BY REPORT

1. Submission of the pathology report is required for payment.
2. A benefit only when provided by a Medi-Cal Dental Program certified oral pathologist.
3. This procedure shall be billed only for a histopathological examination.

PROCEDURE D0999

UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit radiographs as applicable for the type of procedure.
3. Photographs for payment- submit photographs as applicable for the type of procedure.
4. Written documentation for payment shall describe the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.
5. D0999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Preventive General Policies (D1000-D1999)

1. Dental Prophylaxis and Fluoride Treatment (D1110-D1208):
   A) Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.
   B) Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.
   C) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.
   D) The application of fluoride is only a benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.
   E) Prophylaxis and fluoride procedures (D1120, D1206 and D1208) are a benefit once in a six-month period without prior authorization under the age of 21.
   F) Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12-month period without prior authorization for age 21 or older.
   G) Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

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Preventive Procedures (D1000-D1999)

PROCEDURE D1110
PROPHYLAXIS - ADULT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a 12-month period for patients age 21 or older. Frequency limitations shall apply toward prophylaxis procedure D1120.
3. Not a benefit when performed on the same date of service with:
   a. gingivectomy or gingivoplasty (D4210 and D4211).
   b. osseous surgery (D4260 and D4261).
   c. periodontal scaling and root planing (D4341 and D4342).
4. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.

PROCEDURE D1120
PROPHYLAXIS - CHILD

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a six-month period for patients under the age of 21.
3. Not a benefit when performed on the same date of service with:
   a. gingivectomy or gingivoplasty (D4210 and D4211).
   b. osseous surgery (D4260 and D4261).
   c. periodontal scaling and root planing (D4341 and D4342).
4. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.

PROCEDURE D1206
TOPICAL APPLICATION OF FLUORIDE VARNISH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride (D1208).
   b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1208).
3. Payable as a full mouth treatment regardless of the number of teeth treated.

PROCEDURE D1208
TOPICAL APPLICATION OF FLUORIDE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
   b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
3. Payable as a full mouth treatment regardless of the number of teeth treated.

PROCEDURE D1310
NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

PROCEDURE D1320
TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

PROCEDURE D1330
ORAL HYGIENE INSTRUCTIONS

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

PROCEDURE D1351
SEALANT - PER TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
   a. for first, second and third permanent molars that occupy the second molar position.
   b. only on the occlusal surfaces that are free of decay and/or restorations.
   c. for patients under the age of 21.
   d. once per tooth every 36 months per provider regardless of surfaces sealed.
4. The original provider is responsible for any repair or replacement during the 36-month period.

PROCEDURE D1352
PREVENTIVE RESIN RESTORATIONIN A MODERATE TO HIGH CARIES RISK PATIENT-PERMANENT TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
4. for first, second and third permanent molars that occupy the second molar position.
5. only for an active cavitated lesion in a pit or fissure that does not cross the DEJ.
6. for patients under the age of 21.
7. once per tooth every 36 months per provider regardless of surfaces sealed.
8. The original provider is responsible for any repair or replacement during the 36-month period.

PROCEDURE D1510
SPACE MAINTAINER - FIXED UNILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
   a. once per quadrant per patient.
   b. for patients under the age of 18.
   c. only to maintain the space for a single tooth.
6. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.
   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental Program's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1515
SPACE MAINTAINER - FIXED - BILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molars.

4. Requires an arch code.
5. A benefit:
   a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.
   b. for patients under the age of 18.
6. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.
   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental Program's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1520
SPACE MAINTAINER - REMOVABLE - UNILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
   a. once per quadrant per patient.
   b. for patients under the age of 18.
   c. only to maintain the space for a single tooth.
6. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.
   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. All clasps, rests and adjustments are included in the fee for this procedure.

PROCEDURE D1525
SPACE MAINTAINER - REMOVABLE - BILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molars.
4. Requires an arch code.
5. A benefit:
6. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.
7. for patients under the age of 18.
8. Not a benefit:
9. when the permanent tooth is near eruption or is missing.
10. for upper and lower anterior teeth.
11. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
12. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
13. All clasps, rests and adjustments are included in the fee for this procedure.

PROCEDURE D1550
RECEMENTATION OF SPACE MAINTAINER

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

3. Requires a quadrant code or arch code, as applicable.
4. A benefit:
   a. once per provider, per applicable quadrant or arch.
   b. for patients under the age of 18.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D1555

REMOVAL OF FIXED SPACE MAINTAINER

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code or arch code, as applicable.
4. Not a benefit to the original provider who placed the space maintainer.

Restorative General Policies (D2000-D2999)

1. Amalgam and Resin-Based Composite Restorations (D2140-D2394):
   A) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.
   B) Amalgam and resin-based composite restoration procedures shall require submission of pre-operative radiographs for payment, contingent upon the following rules:
      i) the first three amalgam and/or resin-based composite restorations that a patient receives in a 12-month period do not require radiographs,
      ii) the fourth and additional amalgam and/or resin-based composite restorations that a patient receives in a 12-month period do require radiographs. However, when a submitted claim includes the fourth amalgam and/or resin-based composite restoration in a 12-month period then all amalgam and/or resin-based composite restorations on that claim require radiographs.
   C) The submitted radiographs shall clearly demonstrate that the destruction of the tooth is due to such conditions as decay, fracture, endodontic access or missing or defective restorations. Payment for restorative procedures shall be modified or denied when the medical necessity is not evident.
   D) Anterior proximal restorations (amalgam/composite) submitted as a two or three surface restoration shall be clearly demonstrated on radiographs that the tooth structure is involved to a point one-third the mesial–distal width of the tooth.
   E) Should the submitted radiographs fail to demonstrate the medical necessity for the restoration, intraoral photographs shall also be submitted as further documentation.
   F) When radiographs are medically contraindicated due to recent application of therapeutic doses of ionizing radiation to the head and neck areas, the reason for the contraindication shall be fully documented by the patient's attending physician and submitted for payment. If this condition exists, intraoral photographs shall also be submitted to demonstrate the medical necessity for the restoration.
   G) When radiographs fail to demonstrate the medical necessity, providers shall also submit adjunctive documentation for consideration for payment such as: fiber optic transillumination photographs, DIAGNOdent readings, caries detection dye photographs, caries risk assessment data or operating room reports.
   H) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
   I) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
   J) Restorations for primary teeth near exfoliation are not a benefit.
   K) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).
   L) Each separate non-connecting restoration on the same tooth for the same date of service shall be submitted on separate Claim Service Lines (CSLs). All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.
   M) Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.
   N) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.
   O) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage

results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted to demonstrate the need for replacement.

P) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.

2. Prefabricated Crowns (D2929-D2933):
   A) Primary Teeth:
      i) Prefabricated crowns (D2929, D2930, D2932 and D2933) are a benefit only once in a 12-month period.
      ii) Primary teeth do not require prior authorization. Pre-operative radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:
         a. Decay, fracture or other damage involving three or more tooth surfaces,
         b. Decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,
         c. the prefabricated crown is submitted for payment in conjunction with therapeutic pulpotomy or pulpal therapy (D3220, D3230 and D3240) or the tooth has had previous pulpal treatment.
      iii) Prefabricated crowns for primary teeth near exfoliation are not a benefit.
      iv) When prefabricated crowns are utilized to restore space maintainer abutment teeth they shall meet Medi-Cal Dental Program criteria for prefabricated crowns and shall be submitted separately for payment from the space maintainer.
   B) Permanent Teeth:
      i) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.
      ii) Permanent teeth do not require prior authorization. Pre-operative periapical and arch radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:
         a. anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,
         b. bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,
         c. molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,
         d. the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.
      iii) Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.
      iv) Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.
      v) Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy. Post root canal treatment radiographs shall be submitted for prior authorization.
      vi) Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).
   C) Primary and Permanent Teeth:
      i) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
      ii) Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

iii) Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.

iv) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.

v) The original provider is responsible for any replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

3. Laboratory Processed Crowns (D2710-D2792):

A) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5 year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

B) Prior authorization with current periapical and arch radiographs is required. Arch films are not required for crown authorizations if the Medi-Cal Dental Program has paid for root canal treatment on the same tooth within the last six months. Only a periapical radiograph of the completed root canal treatment is required.

C) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:

i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:

ii) the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,

iii) the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,

iv) an incisal angle is not involved but more than 50% of the anatomical crown is involved.

v) Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.

vi) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

vii) Posterior crowns for patients age 21 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.

D) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

E) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

F) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.

G) When a tooth has been restored with amalgam or resin-based composite restoration within 36 months, by the same provider, written documentation shall be submitted with the TAR justifying the medical necessity for the crown request. A current periapical radiograph dated after the restoration is required to demonstrate the medical necessity along with arch radiographs.

H) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns,

occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

I) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5 year prognosis for the teeth to be crowned.

J) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

K) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation.

Restorative Procedures (D2000-D2999)

PROCEDURE D2140
AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

PROCEDURE D2150
AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2160
AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2161
AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2330
RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

PROCEDURE D2331
RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.
5. Each unique tooth surface is only payable once per tooth per date of service.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.
5. Each unique tooth surface is only payable once per tooth per date of service.

PROCEDURE D2332
RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR

See the criteria under Procedure D2331.

PROCEDURE D2335
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)

See the criteria under Procedure D2331.

PROCEDURE D2390
RESIN-BASED COMPOSITE CROWN, ANTERIOR

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. At least four surfaces shall be involved.
5. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. At least four surfaces shall be involved.
5. A benefit once in a 36-month period.

PROCEDURE D2391
RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

PROCEDURE D2392
RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2393
RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2394
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2410
GOLD FOIL - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2420
GOLD FOIL - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2430
GOLD FOIL - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2510
INLAY - METALLIC - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2520
INLAY - METALLIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2530
INLAY - METALLIC - THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2542
ONLAY - METALLIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2543
ONLAY - METALLIC - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2544
ONLAY - METALLIC - FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2610
INLAY - PORCELAIN/CERAMIC - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2620
INLAY - PORCELAIN/CERAMIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2630
INLAY - PORCELAIN/CERAMIC - THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2642
ONLAY - PORCELAIN/CERAMIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2643
ONLAY - PORCELAIN/CERAMIC - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2644
ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2650
INLAY - RESIN-BASED COMPOSITE - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2651
INLAY - RESIN-BASED COMPOSITE - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2652
INLAY - RESIN-BASED COMPOSITE - THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2662
ONLAY- RESIN BASED COMPOSITE- TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2663
ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2664
ONLAY - RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2710
CROWN – RESIN– BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
6. for use as a temporary crown.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit:
   a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
   b. for use as a temporary crown.

PROCEDURE D2712
CROWN – 3/4 RESIN- BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
   c. for use as a temporary crown.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit:
   a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
   b. for use as a temporary crown.

PROCEDURE D2720
CROWN - RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2721
CROWN - RESIN WITH PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2722
CROWN - RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2740
CROWN - PORCELAIN/CERAMIC SUBSTRATE

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the

1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2750
CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2751
CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
   a. for beneficiaries under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2752
CROWN - PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2780
CROWN - 3/4 CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2781
CROWN - 3/4 CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.

4. A benefit once in a five-year period.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five- year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2782
CROWN - 3/4 CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2783
CROWN - 3/4 PORCELAIN / CERAMIC

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five- year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2790
CROWN - FULL CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2791
CROWN - FULL CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
   a. for patients under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five- year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2792
CROWN - FULL CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2794
CROWN - TITANIUM

This procedure is not a benefit.

PROCEDURE D2799
PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

This procedure is not a benefit.

PROCEDURE D2910
RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once in a 12-month period, per provider.

PROCEDURE D2915
RECEMENT CAST OR PREFABRICATED POST AND CORE

This procedure is to be performed in conjunction with the recementation of an existing crown or of a new crown and is not payable separately.

PROCEDURE D2920
RECEMENT CROWN

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D2929
PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.

PROCEDURE D2930
PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.

3. Requires a tooth code.
4. A benefit once in a 12-month period.

PROCEDURE D2931
PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2932
PREFABRICATED RESIN CROWN

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2933
PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.
5. This procedure includes the placement of a resin-based composite.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
6. This procedure includes the placement of a resin-based composite.

PROCEDURE D2934
PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH

This procedure is not a benefit.

PROCEDURE D2940
PROTECTIVE RESTORATION

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once per tooth in a six-month period, per provider.
5. Not a benefit:
   a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
   b. on root canal treated teeth.
6. This procedure is for a temporary restoration and is not to be used as a base or liner under a restoration.

PROCEDURE D2950
CORE BUILDUP, INCLUDING ANY PINS

This procedure is included in the fee for restorative procedures and is not payable separately.

PROCEDURE D2951
PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit pre-operative radiographs.
3. Requires a tooth code.
4. A benefit:
   a. for permanent teeth only.
   b. when billed with an amalgam or composite

restoration on the same date of service.
c. once per tooth regardless of the number of pins placed.
d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or
e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

PROCEDURE D2952
POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once per tooth regardless of number of posts placed.
   b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

PROCEDURE D2953
EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2952 and is not payable separately.

PROCEDURE D2954
PREFABRICATED POST AND CORE IN ADDITION TO CROWN

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once per tooth regardless of number of posts placed.
   b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

PROCEDURE D2955
POST REMOVAL

This procedure is included in the fee for endodontic and restorative procedures and is not payable separately.

PROCEDURE D2957
EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2954 and is not payable separately.

PROCEDURE D2960
LABIAL VENEER (RESIN LAMINATE) – CHAIRSIDE

This procedure is not a benefit.

PROCEDURE D2961
LABIAL VENEER (RESIN LAMINATE) - LABORATORY

This procedure is not a benefit.

PROCEDURE D2962
LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY

This procedure is not a benefit.

PROCEDURE D2970
TEMPORARY CROWN (FRACTURED TOOTH)

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit a pre-operative periapical radiograph.
3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury.
4. Requires a tooth code.
5. A benefit:
   a. once per tooth, per provider.
   b. for permanent teeth only.
6. Not a benefit on the same date of service as:
   a. palliative (emergency) treatment of dental pain-minor procedure (D9110).
   b. office visit for observation (during regularly scheduled hours) - no other services performed (D9430).
7. This procedure is limited to the palliative treatment of traumatic injury only and shall meet the criteria for a laboratory processed crown (D2710-D2792).

PROCEDURE D2971
ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK

This procedure is included in the fee for laboratory processed crowns and is not payable separately.

PROCEDURE D2975
COPING

This procedure is not a benefit.

PROCEDURE D2980
CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a pre-operative periapical radiograph.
3. Photographs for payment - submit a pre-operative photograph.
4. Written documentation for payment - describe the specific conditions addressed by the procedure (such as broken porcelain).
5. Requires a tooth code.
6. A benefit for laboratory processed crowns on permanent teeth.
7. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

PROCEDURE D2981
INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2982
ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2983
VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2990
RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS

This procedure is not a benefit.

PROCEDURE D2999
UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit radiographs as applicable for the type of procedure.
3. Photographs for payment - submit photographs as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Requires a tooth code.
6. D2999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Endodontic General Policies (D3000-D3999)

1. Prior authorization with current periapical radiographs is required for initial root canal therapy (D3310, D3320 and D3330), root canal retreatment (D3346, D3347 and D3348), partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) and apicoectomy/periradicular surgery (D3410, D3421, D3425 and D3426) on permanent teeth.
2. Prior authorization for root canal therapy (D3310, D3320 and D3330) is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.
3. Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.
4. The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non-restorability or periodontal involvement).
5. Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.
6. Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
7. The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.
8. Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date. A post treatment radiograph is not required for payment.
9. Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

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Endodontic Procedures (D3000-D3999)

PROCEDURE D3110
PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3120
PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3220
THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. for a primary tooth with a necrotic pulp or a periapical lesion.
   c. for a primary tooth that is non-restorable.
   d. for a permanent tooth.
6. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.

PROCEDURE D3221
PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
   a. for permanent teeth.
   b. for over-retained primary teeth with no permanent successor.
   c. once per tooth.
5. Not a benefit on the same date of service with any additional services, same tooth.
6. This procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits.Subsequent emergency visits, if medically necessary, shall be billed as palliative (emergency) treatment of dental pain- minor procedure (D9110).

PROCEDURE D3222
PARTIAL PULPOTOMY FOR APEXOGENESIS- PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 21.
5. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure is for vital teeth only.

PROCEDURE D3230
PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical

necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3240
PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3310
ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3320
ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3330
ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348).
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3331
TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3332
INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH

Endodontic treatment is only payable upon successful completion of endodontic therapy.

PROCEDURE D3333
INTERNAL ROOT REPAIR OF PERFORATION DEFECTS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3346
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3347
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3348
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit:
   a. to the original provider within 12 months of initial treatment.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3351
APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION ETC.)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 21.
5. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.
7. If an interim medication replacement is necessary, use apexification/recalcification-interim medication replacement (apical closure/calcific repair of

perforations, root resorption, etc.) (D3352).

8. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3352

APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT

1. Prior authorization is required for D3351, which shall be completed before D3352 is payable.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
   a. only following apexification/ recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (D3351).
   b. once per permanent tooth.
   c. for patients under the age of 21.
5. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes reopening the tooth, placement of medications and all treatment and post treatment radiographs.
7. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3353

APEXIFICATION/ RECALCIFICATION - FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY - APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)

This procedure is not a benefit. Upon completion of apexification/ recalcification, prior authorization for the final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3354

PULPAL REGENERATION - (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION

This procedure is not a benefit.

PROCEDURE D3410

APICOECTOMY/ PERIRADICULAR SURGERY - ANTERIOR

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent anterior teeth only.
6. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3421

APICOECTOMY/ PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the

medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent bicuspid teeth only.
6. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).

PROCEDURE D3425
APICOECTOMY/ PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent 1st and 2nd molar teeth only.
6. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).

PROCEDURE D3426
APICOECTOMY/ PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
7. Only payable the same date of service as procedures D3421 or D3425.
8. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3430
RETROGRADE FILLING - PER ROOT

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3450
ROOT AMPUTATION – PER ROOT

This procedure is not a benefit.

PROCEDURE D3460
ENDODONTIC ENDOSSEOUS IMPLANT

This procedure is not a benefit.

PROCEDURE D3470
INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)

This procedure is not a benefit.

PROCEDURE D3910
SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3920
HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY

This procedure is not a benefit.

PROCEDURE D3950
CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST

This procedure is not a benefit.

PROCEDURE D3999
UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit arch and pre-operative periapical radiographs as applicable for the type of procedure.
3. Photographs for payment- submit as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
5. Requires a tooth code.
6. Procedure D3999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Periodontal General Policies (D4000-D4999)`

1. Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.
2. Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4290) and periodontal maintenance (D4910).
3. Current periapical radiographs of the involved areas and bitewing radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. A panoramic radiographic image alone is non- diagnostic for periodontal procedures.
4. Photographs are required for gingivectomy or gingivoplasty (D4210 and D4211) for prior authorizations.
5. Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:
   A) a full quadrant is considered to have four or more qualifying diseased teeth,
   B) a partial quadrant is considered to have one, two, or three diseased teeth,
   C) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
6. Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.
7. Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.
8. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.
9. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.
10. Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.
11. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.
12. Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.
13. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

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Periodontal Procedures (D4000-D4999)

PROCEDURE D4210
GINGIVECTOMY OR GINGIVOPLASTY- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

PROCEDURE D4211
GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

PROCEDURE D4212
GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4230
ANATOMICAL CROWN EXPOSURE- FOUR OR MORE CONTIGUOUS TEETH PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4231
ANATOMICAL CROWN EXPOSURE- ONE TO THREE TEETH PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4240
GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4241
GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES, PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4245
APICALLY POSITIONED FLAP

This procedure is not a benefit.

PROCEDURE D4249
CLINICAL CROWN LENGTHENING – HARD TISSUE

This procedure is included in the fee for a completed restorative service.

PROCEDURE D4260
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30

days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

7. This procedure can only be prior authorized when preceded by periodontal scaling and root planning (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4261
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES, PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
7. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4263
BONE REPLACEMENT GRAFT – FIRST SITE IN QUADRANT

This procedure is not a benefit.

PROCEDURE D4264
BONE REPLACEMENT GRAFT – EACH ADDITIONAL SITE IN QUADRANT

This procedure is not a benefit.

PROCEDURE D4265
BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4266
GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER SITE

This procedure is not a benefit.

PROCEDURE D4267
GUIDED TISSUE REGENERATION – NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)

This procedure is not a benefit.

PROCEDURE D4268
SURGICAL REVISION PROCEDURE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4270
PEDICLE SOFT TISSUE GRAFT PROCEDURE

This procedure is not a benefit.

PROCEDURE D4273
SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4274
PROCEDURE DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)

This procedure is not a benefit.

PROCEDURE D4275
SOFT TISSUE ALLOGRAFT

This procedure is not a benefit.

PROCEDURE D4276
COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4277
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT

This procedure is not a benefit.

PROCEDURE D4278
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE

This procedure is not a benefit.

PROCEDURE D4320
PROVISIONAL SPLINTING – INTRACORONAL

This procedure is not a benefit.

PROCEDURE D4321
PROVISIONAL SPLINTING – EXTRACORONAL

This procedure is not a benefit.

PROCEDURE D4341
PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4342).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 24 months.
6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

PROCEDURE D4342
PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4341).
5. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 24 months.
6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

PROCEDURE D4355
FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4381
LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4910
PERIODONTAL MAINTENANCE

1. This procedure does not require prior authorization.
2. A benefit:
   a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
   b. only when preceded by a periodontal scaling and root planing (D4341-D4342).
   c. only after completion of all necessary scaling and root planings.
   d. once in a calendar quarter.
   e. only in the 24 month period following the last scaling and root planing.
3. Not a benefit in the same calendar quarter as scaling and root planing.
4. Not payable to the same provider in the same calendar quarter as prophylaxis- adult (D1110) or prophylaxis- child (D1120).
5. This procedure is considered a full mouth treatment.

PROCEDURE D4920

UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include a brief description indicating the medical necessity.
3. A benefit:
   a. for patients age 13 or older.
   b. once per patient per provider.
   c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
4. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

PROCEDURE D4999

UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit as applicable for the type of procedure.
3. Photographs for prior authorization- shall be submitted.
4. Written documentation for prior authorization –shall include the specific treatment requested and etiology of the disease or condition.
5. Requires a tooth or quadrant code, as applicable for the type of procedure.
6. A benefit for patients age 13 or older.
7. Procedure D4999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Prosthodontics (Removable) General Policies (D5000-D5899)

1. Complete and Partial Dentures (D5110-D5214 and D5860):
   A) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140).
   B) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.
   C) Current radiographs of all remaining natural teeth and implants and a properly completed prosthetic Justification of Need For Prosthesis Form, DC054 (10/05) are required for prior authorization. A panoramic radiographic image shall be considered diagnostic for edentulous areas only.
   D) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR.
   E) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see “g” below).
   F) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.
   G) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.
   H) Providers shall use the laboratory order date as the date of service when submitting for payment of a prior authorized removable prosthesis. The laboratory order date is the date when the prosthesis is sent to the laboratory for final fabrication. Full payment shall not be requested until the prosthesis is delivered and is in use by the patient.
   I) Partial payment of an undeliverable completed removable prosthesis shall be considered when the reason for non-delivery is adequately documented on the Notice of Authorization (NOA) and is accompanied by a laboratory invoice indicating the prosthesis was processed. The completed prosthesis shall be kept in the provider’s office, in a deliverable condition, for a period of at least one year.
   J) A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:
      i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or
      ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or
      iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.
   K) Prosthodontic services provided solely for cosmetic purposes are not a benefit.
   L) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
   M) Spare or backup dentures are not a benefit.
   N) Evaluation of a denture on a maintenance basis is not a benefit.
   O) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.
   P) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:
      i) extensive or rampant caries are exhibited in the radiographs,
      ii) severe periodontal involvement is indicated in the radiographs,
      iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient’s health.
   Q) There is no insertion fee payable to an oral surgeon who seats an immediate denture.

R) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.

S) Partial dentures are not a benefit to replace missing 3rd molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):

A) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that required extractions.

B) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

C) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211and D5212).

D) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).

E) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that required extractions.

F) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

G) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).

H) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.

I) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that required extractions.

Prosthodontic (Removable) Procedures (D5000-D5899)

PROCEDURE D5110
COMPLETE DENTURE – MAXILLARY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-maxillary (D5130) or overdenture- complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5120
COMPLETE DENTURE – MANDIBULAR

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-mandibular (D5140) or overdenture-complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5130
IMMEDIATE DENTURE – MAXILLARY

1. Prior authorization is not required.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.
4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

PROCEDURE D5140
IMMEDIATE DENTURE – MANDIBULAR

1. Prior authorization is not required.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.
4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5751) or chairside reline (D5731) is a benefit six months after the date of service for this procedure.

PROCEDURE D5211

MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is not a benefit for this procedure.
9. Chairside reline (D5740) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5212

MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5761) is not a benefit for this procedure.
9. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5213

MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks

posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5740) is a benefit:
   a. once in a 12 month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5214

MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5761) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5225

MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5226

MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5281

REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5410
ADJUST COMPLETE DENTURE - MAXILLARY

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
3. Not a benefit:
   a. same date of service or within six months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130)or overdenture-complete (D5860).
   b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
   c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth- complete denture (D5520).

PROCEDURE D5411
ADJUST COMPLETE DENTURE – MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. once per date of service per provider.
4. twice in a 12-month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture-complete (D5860).
7. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).
8. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5421
ADJUST PARTIAL DENTURE – MAXILLARY

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. once per date of service per provider.
4. twice in a 12-month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a maxillary partial- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213).
7. same date of service or within six months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).
8. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5422
ADJUST PARTIAL DENTURE - MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:

3. once per date of service per provider.
4. twice in a 12 month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a mandibular partial-resin base (D5212) or mandibular partial denture-cast metal framework with resin denture bases (D5214).
7. same date of service or within six months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).
8. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5510
REPAIR BROKEN COMPLETE DENTURE BASE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
4. once per arch, per date of service per provider.
5. twice in a 12-month period per provider.
6. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
7. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5520
REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5610
REPAIR RESIN DENTURE BASE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
   c. for partial dentures only.
4. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5620
REPAIR CAST FRAMEWORK

1. Requires a laboratory invoice for payment.
2. Requires an arch code.
3. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5630
REPAIR OR REPLACE BROKEN CLASP

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5640
REPLACE BROKEN TEETH – PER TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
   c. for partial dentures only.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5650
ADD TOOTH TO EXISTING PARTIAL DENTURE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
2. Requires a tooth code.
3. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. once per tooth.
4. Not a benefit for adding 3rd molars.
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5660
ADD CLASP TO EXISTING PARTIAL DENTURE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
2. Requires an arch code.
3. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5670
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)

This procedure is not a benefit.

PROCEDURE D5671
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)

This procedure is not a benefit.

PROCEDURE D5710
REBASE COMPLETE MAXILLARY DENTURE

This procedure is not a benefit.

PROCEDURE D5711
REBASE COMPLETE MANDIBULAR DENTURE

This procedure is not a benefit.

PROCEDURE D5720
REBASE MAXILLARY PARTIAL DENTURE

This procedure is not a benefit.

PROCEDURE D5721
REBASE MANDIBULAR PARTIAL DENTURE

This procedure is not a benefit.

PROCEDURE D5730
RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:

a. once in a 12-month period.
b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
c. 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture (remote)-complete (D5860) that did not require extractions.

3. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5731
RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-mandibular (D5120) or overdenture (remote)-complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5740
RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
   c. 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5741
RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or
   c. 12 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions.
3. Not a benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).
4. All adjustments made for six months after the date of service, by the same provider,

are included in the fee for this procedure.

PROCEDURE D5750
RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture (remote)-complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5751
RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) - complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5760
RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
   c. 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit:
   a. within 12 months of a reline maxillary partial denture (chairside) (D5740).
   b. for a maxillary partial denture- resin base (D5211).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5761
RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or
   c. 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases

(D5214) that did not require extractions.

3. Not a benefit:
   a. within 12 months of a reline mandibular partial denture (chairside) (D5741).
   b. for a mandibular partial denture- resin base (D5212).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5810
INTERIM COMPLETE DENTURE (MAXILLARY)

This procedure is not a benefit.

PROCEDURE D5811
INTERIM COMPLETE DENTURE (MANDIBULAR)

This procedure is not a benefit.

PROCEDURE D5820
INTERIM PARTIAL DENTURE (MAXILLARY)

This procedure is not a benefit.

PROCEDURE D5821
INTERIM PARTIAL DENTURE (MANDIBULAR)

This procedure is not a benefit.

PROCEDURE D5850
TISSUE CONDITIONING, MAXILLARY

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice per prosthesis in a 36-month period.
3. Not a benefit:
   a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760).
   b. same date of service as a prosthesis that did not require extractions.
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5851
TISSUE CONDITIONING, MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice per prosthesis in a 36-month period.
3. Not a benefit:
   a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761).
   b. same date of service as a prosthesis that did not require extractions.
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5860
OVERDENTURE – COMPLETE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit all radiographs of remaining natural teeth including periapical radiographs of teeth to be retained.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required, that includes which teeth are to be retained, for prior authorization.
4. Requires an arch code.
5. A benefit once in a five-year period.
6. Complete denture laboratory relines (D5750 and D5751) are a benefit:
   a. six months after the date of service for an immediate overdenture that required extractions, or
   b. 12 months after the date of service for a complete

overdenture that did not require extractions.

7. Complete denture chairside relines (D5730 and D5731) are a benefit:
   a. six months after the date of service for an immediate overdenture that required extractions, or
   b. 12 months after the date of service for a complete overdenture that did not require extractions.
8. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
9. Teeth to be retained are not eligible for preventative, periodontal, endodontic or restorative procedures. Only extractions for the retained teeth shall be a benefit.

PROCEDURE D5861
OVERDENTURE – PARTIAL, BY REPORT

This procedure is not a benefit.

PROCEDURE D5862
PRECISION ATTACHMENT, BY REPORT

This procedure is included in the fee for prosthetic and restorative procedures and is not payable separately.

PROCEDURE D5867
REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT)

This procedure is not a benefit.

PROCEDURE D5875
MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY.

This procedure is not a benefit.

PROCEDURE D5899
UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Submit a current and complete Justification of Need For Prosthesis Form, DC054 (10/05), if applicable for the type of procedure, for prior authorization.
5. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
6. Procedure D5899 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment

Maxillofacial Prosthetics General Policies (D5900-D5999)

1. Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
2. All maxillofacial prosthetic procedures require written documentation for payment or prior authorization. Refer to the individual procedures for specific requirements.
3. Prior authorization is required for the following procedures:
   A) trismus appliance (D5937),
   B) palatal lift prosthesis, interim (D5958),
   C) fluoride gel carrier (D5986),
   D) surgical splint (D5988).
4. All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

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Maxillofacial Prosthetic Procedures (D5900-D5999)

PROCEDURE D5911
FACIAL MOULAGE (SECTIONAL)

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.

PROCEDURE D5912
FACIAL MOULAGE (COMPLETE)

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.

PROCEDURE D5913
NASAL PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.

PROCEDURE D5914
AURICULAR PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.

PROCEDURE D5915
ORBITAL PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.

PROCEDURE D5916
OCULAR PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.
   c. Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

PROCEDURE D5919
FACIAL PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.

PROCEDURE D5922
NASAL SEPTAL PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.

PROCEDURE D5923
OCULAR PROSTHESIS, INTERIM

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.
   c. Not a benefit on the same date of service with an ocular prosthesis (D5916).

PROCEDURE D5924
CRANIAL PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.

PROCEDURE D5925
FACIAL AUGMENTATION IMPLANT PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and

c. a description of the prosthesis.

PROCEDURE D5926
NASAL PROSTHESIS, REPLACEMENT

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5927
AURICULAR PROSTHESIS, REPLACEMENT

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5928
ORBITAL PROSTHESIS, REPLACEMENT

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5929
FACIAL PROSTHESIS, REPLACEMENT

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5931
OBTURATOR PROSTHESIS, SURGICAL

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5932
OBTURATOR PROSTHESIS, DEFINITIVE

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).

PROCEDURE D5933
OBTURATOR PROSTHESIS, MODIFICATION

1. Written documentation for payment - shall include the medical necessity for the modification.
2. A benefit twice in a 12 month period.
3. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5934
MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.

PROCEDURE D5935
MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.

PROCEDURE D5936
OBTURATOR PROSTHESIS, INTERIM

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report, and
   c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

PROCEDURE D5937
TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)

1. Prior authorization is required.

2. Written documentation for prior authorization - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery.

PROCEDURE D5951
FEEDING AID

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients under the age of 18.

PROCEDURE D5952
SPEECH AID PROSTHESIS, PEDIATRIC

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients under the age of 18.

PROCEDURE D5953
SPEECH AID PROSTHESIS, ADULT

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients age 18 or older.

PROCEDURE D5954
PALATAL AUGMENTATION PROSTHESIS

Written documentation for payment - shall include the treatment performed.

PROCEDURE D5955
PALATAL LIFT PROSTHESIS, DEFINITIVE

1. Written documentation for payment - shall include the treatment performed.
2. Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).'

PROCEDURE D5958
PALATAL LIFT PROSTHESIS, INTERIM

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include the treatment to be performed.
3. Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).

PROCEDURE D5959
PALATAL LIFT PROSTHESIS, MODIFICATION

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).

PROCEDURE D5960
SPEECH AID PROSTHESIS, MODIFICATION

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).

PROCEDURE D5982
SURGICAL STENT

Written documentation for payment - shall include the treatment performed.

PROCEDURE D5983
RADIATION CARRIER

1. Written documentation for payment - shall include the etiology of the disease and/or condition.
2. Requires an arch code.

PROCEDURE D5984
RADIATION SHIELD

Written documentation for payment - shall include the etiology of the disease and/or condition.

PROCEDURE D5985
RADIATION CONE LOCATOR

Written documentation for payment - shall include the etiology of the disease and/or condition.

PROCEDURE D5986
FLUORIDE GEL CARRIER

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include the etiology of the disease and/or condition and the treatment to be performed.
3. Requires an arch code.
4. A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

PROCEDURE D5987
COMMISSURE SPLINT

Written documentation for payment - shall include the etiology of the disease and/or condition.

PROCEDURE D5988
SURGICAL SPLINT

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs.
3. Written documentation for prior authorization –- shall include the medical necessity and the treatment to be performed.

PROCEDURE D5991
TOPICAL MEDICAMENT CARRIER

1. Written documentation for payment - shall include the etiology of the disease and/or condition.
2. Requires an arch code.

PROCEDURE D5992
ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT

This procedure is not a benefit.

PROCEDURE D5993
MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT

This procedure is not a benefit.

PROCEDURE D5999
UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation or operative report for prior authorization or payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Procedure D5999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Implant Services General Policies (D6000-D6199)

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Medi-Cal Dental Program for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
   A) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
   B) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
   C) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
   D) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
2. Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
3. Single tooth implants are not a benefit of the Medi-Cal Dental Program.
4. Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

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Implant Service Procedures (D6000-D6199)

PROCEDURE D6010
SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
2. Prior authorization is required.
3. Radiographs for prior authorization - submit arch, pre-operative periapical and/or panoramic radiographs as applicable.
4. Photographs for prior authorization - submit as applicable.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

PROCEDURE D6040
SURGICAL PLACEMENT: EPOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6050
SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6051
INTERIM ABUTMENT

This procedure is not a benefit.

PROCEDURE D6053
IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6054
IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6055
CONNECTING BAR – IMPLANT SUPPORTED OR ABUTMENT SUPPORTED

See the criteria for Procedure D6010.

PROCEDURE D6056
PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6057
CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6058
ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6059
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6060
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6061
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6062
ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6063
ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6064
ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6065
IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6066
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6067
IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6068
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6069
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6070
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6071
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6072
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6073
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6074
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6075
IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6076
IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6077
IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6078
IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6079
IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6080
IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS

See the criteria for Procedure D6010.

PROCEDURE D6090
REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6091
REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

See the criteria for Procedure D6010.

PROCEDURE D6092
RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written

documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6093
RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported fixed partial dentures.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6094
ABUTMENT SUPPORTED CROWN (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6095
REPAIR IMPLANT ABUTMENT, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6100
IMPLANT REMOVAL, BY REPORT

1. Prior authorization is not required.
2. Radiographs for payment – submit a radiograph of the implant to be removed.
3. Written documentation for payment –shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a tooth code.

PROCEDURE D6101
PROCEDURE DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SERVICES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6102
PROCEDURE DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6103
BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT - NOT INCLUDING FLAP ENTRY AND CLOSURE OR, WHEN INDICATED, PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION

This procedure is not a benefit.

PROCEDURE D6104
BONE GRAFT AT TIME OF IMPLANT PLACEMENT

This procedure is not a benefit.

PROCEDURE D6190
RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT

This procedure is included in the fee for surgical placement of implant body: endosteal implant (D6010).

PROCEDURE D6194
ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6199
UNSPECIFIED IMPLANT PROCEDURE, BY REPORT

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
2. Prior authorization is required.
3. Radiographs for prior authorization - submit arch and pre-operative periapical radiographs.

4. Photographs for prior authorization - submit as applicable for the type of procedure.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

Fixed Prosthodontic General Policies (D6200-D6999)

1. Fixed partial dentures (bridgework) are considered beyond the scope of the Medi-Cal Dental Program. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.
2. Medical conditions, which preclude the use of a removable partial denture, include:
   A) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
   B) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
   C) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.
3. Documentation for medical conditions shall be submitted for prior authorization that includes a written, signed and dated statement from the patient's physician, on their professional letterhead, describing the patient's medical condition and the reason why a removable partial denture would be injurious to the patient's health.
4. Documentation for obtaining employment shall be submitted for prior authorization that includes a written statement from the patient's case manager or eligibility worker stating why the nature of the employment precludes the use of a removable partial denture.
5. Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.
6. Current periapical radiographs of the retainer (abutment) teeth and arch radiographs are required for prior authorization.
7. Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
8. Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
9. Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.
10. Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization. Prior authorization shall be based upon a supportable five-year prognosis for the fixed partial denture retainer (abutment).
11. Fixed partial denture retainers (abutments) on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of fixed partial dentures.
12. Partial payment will not be made for an undelivered fixed partial denture. Payment will be made only upon final cementation.
13. Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.
14. Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

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Fixed Prosthodontic Procedures (D6200-D6999)

PROCEDURE D6205
PONTIC – INDIRECT RESIN BASED COMPOSITE

This procedure is not a benefit.

PROCEDURE D6210
PONTIC – CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6211
PONTIC – CAST PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6212
PONTIC – CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6214
PONTIC – TITANIUM

This procedure is not a benefit.

PROCEDURE D6240
PONTIC – PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6241
PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6242
PONTIC – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6245
PONTIC – PORCELAIN/CERAMIC

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6250
PONTIC – RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6251
PONTIC – RESIN WITH PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6252
PONTIC – RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6253
PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

This procedure is not a benefit.

PROCEDURE D6545
RETAINER – CAST METAL FOR RESIN BONDED FIXED PROSTHESIS

This procedure is not a benefit.

PROCEDURE D6548
RETAINER – PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS

This procedure is not a benefit.

PROCEDURE D6600
INLAY – PORCELAIN/CERAMIC, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6601
INLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6602
INLAY – CAST HIGH NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6603
INLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6604
INLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6605
INLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6606
INLAY – CAST NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6607
INLAY – CAST NOBLE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6608
ONLAY – PORCELAIN/CERAMIC, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6609
ONLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6610
ONLAY – CAST HIGH NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6611
ONLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6612
ONLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6613
ONLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6614
ONLAY – CAST NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

PROCEDURE D6615
ONLAY – CAST NOBLE METAL, THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D6624
INLAY- TITANIUM

This procedure is not a benefit.

PROCEDURE D6634
ONLAY- TITANIUM

This procedure is not a benefit.

PROCEDURE D6710
CROWN- INDIRECT RESIN BASED COMPOSITE

This procedure is not a benefit.

PROCEDURE D6720
CROWN – RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6721
CROWN – RESIN WITH PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6722
CROWN – RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6740
CROWN – PORCELAIN/CERAMIC

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6750
CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6751
CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6752
CROWN – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6780
CROWN – ¾ CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6781
CROWN – ¾ CAST PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6782
CROWN – ¾ CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6783
CROWN – ¾ PORCELAIN/ CERAMIC

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6790
CROWN – FULL CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6791
CROWN – FULL CAST PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6792
CROWN – FULL CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6793
PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

This procedure is not a benefit.

PROCEDURE D6794
CROWN- TITANIUM

This procedure is not a benefit.

PROCEDURE D6920
CONNECTOR BAR

This procedure is not a benefit.

PROCEDURE D6930
RECEMENT FIXED PARTIAL DENTURE

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of a fixed partial denture.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6940
STRESS BREAKER

This procedure is not a benefit.

PROCEDURE D6950
PRECISION ATTACHMENT

This procedure is not a benefit.

PROCEDURE D6975
COPING

This procedure is not a benefit.

PROCEDURE D6980
FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit pre-operative radiographs of the retainers.
3. Photographs for payment – submit a pre-operative photograph.
4. Written documentation for payment- describe the specific conditions addressed by the procedure.
5. Submit a laboratory invoice, if applicable for the type of procedure, for payment.
6. Requires a tooth code.
7. Not a benefit within 12 months of initial placement or previous repair, same provider.

PROCEDURE D6985
PEDIATRIC PARTIAL DENTURE, FIXED

This procedure is not a benefit.

PROCEDURE D6999
UNSPECIFIED, FIXED PROSTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit periapical radiographs.
3. Photographs for prior authorization – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization – describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
5. Requires a tooth code.
6. Not a benefit within 12 months of initial placement, same provider.
7. Procedure D6999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

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Oral and Maxillofacial Surgery General Policies (D7000-D7999)

1. Diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure for specific requirements.
2. Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.
3. The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.
4. Extractions (D7111-D7250):
   A) The following conditions shall be considered medically necessary and shall be a benefit:
      i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,
      ii) teeth which are involved with a cyst, tumor or other neoplasm,
      iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,
      iv) the extraction of all remaining teeth in preparation for a full prosthesis,
      v) extraction of third molars that are causing repeated or chronic pericoronitis
      vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,
      vii) perceptible radiologic pathology that fails to elicit symptoms,
      viii) extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars,
      ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
   B) The prophylactic extraction of 3rd molars is not a benefit.
   C) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.
   D) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.
   E) The level of payment for surgical extractions shall be allowed or modified based on the degree of difficulty as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered.
5. Fractures (D7610-D7780):
   A) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.
   B) Routine postoperative care within 90 days is included in the fee for the associated procedure.
   C) When extensive multiple or bilateral procedures are performed at the same operative session, each procedure shall be valued as follows:
      i) 100% (full value) for the first or major procedure, and
      ii) 50% for the second procedure, and
      iii) 25% for the third procedure, and
      iv) 10% for the fourth procedure, and
      v) 5% for the fifth procedure, and
      vi) over five procedures, by report.
   D) Assistant surgeons are paid 20% of the surgical fee allowed to the surgeon. Hospital call (D9420) is not payable to assistant surgeons.
6. Temporomandibular Joint Dysfunctions (D7810-D7899):

Oral and Maxillofacial Surgery Procedures (D7000-D7999)

A) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

B) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.

C) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

7. Repair Procedures (D7910-D7998):

A) Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

Oral and Maxillofacial Surgery Procedures (D7000-D7999)

PROCEDURE D7111
EXTRACTION, CORONAL REMNANTS – DECIDUOUS TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit for asymptomatic teeth.

PROCEDURE D7140
EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7210
SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.

PROCEDURE D7220
REMOVAL OF IMPACTED TOOTH – SOFT TISSUE

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.

PROCEDURE D7230
REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

PROCEDURE D7240
REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.

PROCEDURE D7241
REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Written documentation for payment – shall justify the unusual surgical complication.
3. Requires a tooth code.
4. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.

PROCEDURE D7250
SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire root.
2. Requires a tooth code.

3. A benefit when the root is completely covered by alveolar bone.
4. Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7251
CORONECTOMY- INTENTIONAL PARTIAL TOOTH REMOVAL

This procedure is not a benefit.

PROCEDURE D7260
ORAL ANTRAL FISTULA CLOSURE

1. Radiographs for payment - submit a current, diagnostic preoperative radiograph.
2. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
5. Not a benefit in conjunction with extraction procedures (D7111 – D7250).

PROCEDURE D7261
PRIMARY CLOSURE OF A SINUS PERFORATION

1. Radiographs for payment - submit a current, diagnostic preoperative radiograph.
2. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a tooth code.
4. A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.

PROCEDURE D7270
TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH

1. Radiographs for payment – submit a preoperative periapical radiograph.
2. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the tooth/teeth reimplanted.
3. Requires an arch code.
4. A benefit:
   a. once per arch regardless of the number of teeth involved, and
   b. for permanent anterior teeth only.
5. The fee for this procedure includes splinting and/or stabilization, postoperative care and the removal of the splint or stabilization, by the same provider.

PROCEDURE D7272
TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)

This procedure is not a benefit.

PROCEDURE D7280
SURGICAL ACCESS OF AN UNERUPTED TOOTH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. Not a benefit:
   a. for patients age 21 or older.
   b. for 3rd molars.

PROCEDURE D7282
MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION

This procedure is not a benefit.

PROCEDURE D7283
PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires a tooth code.
5. A benefit only for patients in active orthodontic treatment.
6. Not a benefit:

a. for patients age 21 years or older.
b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7285
BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)

1. Radiographs for payment – submit a pre-operative radiograph.
2. A pathology report from a certified pathology laboratory is required for payment.
3. Requires an arch code.
4. A benefit:
   a. for the removal of the specimen only.
   b. once per arch, per date of service regardless of the areas involved.
5. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7286
BIOPSY OF ORAL TISSUE – SOFT

1. Written documentation for payment – shall include the area or region and individual areas biopsied.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit:
   a. for the removal of the specimen only.
   b. up to a maximum of three per date of service.
4. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7287
EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION

This procedure is not a benefit.

PROCEDURE D7288
BRUSH BIOPSY- TRANSEPITHELIAL SAMPLE COLLECTION

This procedure is not a benefit.

PROCEDURE D7290
SURGICAL REPOSITIONING OF TEETH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires an arch code.
5. A benefit:
   a. for permanent teeth only.
   b. once per arch.
   c. only for patients in active orthodontic treatment.
6. Not a benefit:
   a. for patients age 21 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7291
TRANSSEPTAL FIBEROTOMY/ SUPRA CRESTAL FIBEROTOMY, BY REPORT

1. Written documentation for payment – shall indicate that the patient is under active orthodontic treatment.
2. Requires an arch code.
3. A benefit:
   a. once per arch.
   b. only for patients in active orthodontic treatment.
4. Not a benefit for patients age 21 or older.

PROCEDURE D7292
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7293
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7294
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7295
HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE

This procedure is not a benefit.

PROCEDURE D7310

ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. Radiographs for payment – submit radiographs of the involved areas.
2. Requires a quadrant code.
3. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
4. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

PROCEDURE D7311

ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7310).

PROCEDURE D7320

ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. Radiographs for payment- submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.
2. Photographs for payment- submit photographs of the involved areas.
3. Requires a quadrant code.
4. A benefit regardless of the number of teeth or tooth spaces.
5. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

PROCEDURE D7321

ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7320).

PROCEDURE D7340

VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.
4. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once in a five year period per arch.
7. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7350

VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.
4. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once per arch.
7. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7410
EXCISION OF BENIGN LESION UP TO 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7411
EXCISION OF BENIGN LESION GREATER THAN 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7412
EXCISION OF BENIGN LESION, COMPLICATED

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7413
EXCISION OF MALIGNANT LESION UP TO 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7414
EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7415
EXCISION OF MALIGNANT LESION, COMPLICATED

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7440
EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7441
EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7450
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the

area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7451
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7460
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7461
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7465
PROCEDURE DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Examples include using cryo, laser or electro surgery.

PROCEDURE D7471
REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)

1. Photographs for payment – submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit:
   a. once per quadrant.
   b. for the removal of buccal or facial exostosis only.

PROCEDURE D7472
REMOVAL OF TORUS PALATINUS

1. Photographs for payment – submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. A benefit once in the patient's lifetime.

PROCEDURE D7473
REMOVAL OF TORUS MANDIBULARIS

1. Photographs for payment – submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7485
SURGICAL REDUCTION OF OSSEOUS TUBEROSITY

1. Radiographs for payment – submit preoperative radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7490
RADICAL RESECTION OF MAXILLA OR MANDIBLE

1. Radiographs for payment – submit radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

PROCEDURE D7510
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7511
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE- COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7520
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7521
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE- COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision,

placement and removal of a surgical draining device.

PROCEDURE D7530
REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

PROCEDURE D7540
REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

PROCEDURE D7550
PARTIAL OSTECTOMY/ SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit:
   a. once per quadrant per date of service.
   b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
5. Not a benefit within 30 days of an associated extraction (D7111-D7250).

PROCEDURE D7560
MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

PROCEDURE D7610
MAXILLA – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7620
MAXILLA – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate

benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7630
MANDIBLE – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7640
MANDIBLE – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7650
MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7660
MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7670
ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7671
ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the

operative report which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7680
FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of simple fractures.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7710
MAXILLA – OPEN REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7720
MAXILLA – CLOSED REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7730
MANDIBLE – OPEN REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7740
MANDIBLE – CLOSED REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for

the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7750
MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7760
MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7770
ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7771
ALVEOLUS – CLOSED REDUCTION STABILIZATION OF TEETH

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7780
FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of compound fractures.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7810
OPEN REDUCTION OF DISLOCATION

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical

necessity, the location (left or right) and any pertinent history.

PROCEDURE D7820
CLOSED REDUCTION OF DISLOCATION

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7921
COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT

This procedure is not a benefit.

PROCEDURE D7830
MANIPULATION UNDER ANESTHESIA

1. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary.

PROCEDURE D7840
CONDYLECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7850
SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7852
PROCEDURE DISC REPAIR

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7854
SYNOVECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7856
MYOTOMY

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7858
JOINT RECONSTRUCTION

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7860
ARTHROTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7865
ARTHROPLASTY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7870
ARTHROCENTESIS

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7871
NON-ARTHROSCOPIC LYSIS AND LAVAGE

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D7872
ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.
5. This procedure includes the fee for any biopsies performed.

PROCEDURE D7873
ARTHROSCOPY – SURGICAL: LAVAGE AND LYSIS OF ADHESIONS

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7874
ARTHROSCOPY – SURGICAL: DISC REPOSITIONING AND STABILIZATION

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7875
ARTHROSCOPY – SURGICAL: SYNOVECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7876
ARTHROSCOPY – SURGICAL: DISCECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7877
ARTHROSCOPY – SURGICAL: DEBRIDEMENT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7880
OCCLUSAL ORTHOTIC DEVICE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit tomograms or a radiological report.
3. Written documentation for prior authorization – shall include the specific TMJ conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit for diagnosed TMJ dysfunction.
5. Not a benefit for the treatment of bruxism.

PROCEDURE D7899
UNSPECIFIED TMD THERAPY, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization – submit radiographs and/or tomograms, if applicable, for the type of procedure.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

PROCEDURE D7910
SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7911
COMPLICATED SUTURE – UP TO 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7912
COMPLICATED SUTURE – GREATER THAN 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7920
SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
2. Not a benefit for periodontal grafting.

PROCEDURE D7921
COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT

This procedure is not a benefit

PROCEDURE D7940
OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. An operative report shall be submitted for payment.

PROCEDURE D7941
OSTEOTOMY – MANDIBULAR RAMI

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7943
OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7944
OSTEOTOMY – SEGMENTED OR SUBAPICAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a quadrant code.
5. An operative report shall be submitted for payment.

PROCEDURE D7945
OSTEOTOMY – BODY OF MANDIBLE

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7946
LEFORT I (MAXILLA – TOTAL)

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7947
LEFORT I (MAXILLA – SEGMENTED)

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.
3. When reporting a surgically assisted palatal expansion without downfracture, use unspecified oral surgery procedure, by report (D7999).

PROCEDURE D7948
LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) – WITHOUT BONE GRAFT

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7949
LEFORT II OR LEFORT III – WITH BONE GRAFT

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7950
OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT

3. Prior authorization is required.
4. Radiographs for prior authorization –submit a radiograph.
5. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Not a benefit for periodontal grafting.
7. An operative report shall be submitted for payment.

PROCEDURE D7951
SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

PROCEDURE D7952
SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTE VIA A VERTICAL APPROACH

1. Prior authorization is required.
2. Radiographs for prior authorization -submit a radiograph.
3. Written documentation for prior authorization - shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

PROCEDURE D7953
BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION- PER SITE

This procedure is not a benefit.

PROCEDURE D7955
REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7960
FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY – SEPARATE PROCEDURE NOT IDENTICAL TO ANOTHER

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit
   a. once per arch per date of service
   b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7963
FRENULOPLASTY

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit
   a. once per arch per date of service.
   b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7970
EXCISION OF HYPERPLASTIC TISSUE – PER ARCH

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit once per arch per date of service.
5. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
6. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

PROCEDURE D7971
EXCISION OF PERICORONAL GINGIVA

1. Radiographs for payment- submit a pre-operative periapical radiograph.
2. Photographs for payment – submit a pre-operative photograph only when the radiograph does not adequately demonstrate the medical necessity.
3. Written documentation for payment – shall include the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

PROCEDURE D7972
SURGICAL REDUCTION OF FIBROUS TUBEROSITY

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant per date of service.
5. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service.

PROCEDURE D7980
SIALOLITHOTOMY

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation or operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7981
EXCISION OF SALIVARY GLAND, BY REPORT

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7982
SIALODOCHOPLASTY

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7983
CLOSURE OF SALIVARY FISTULA

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7990
EMERGENCY TRACHEOTOMY

Operative report for payment – shall include the specific conditions addressed by the procedure.

PROCEDURE D7991
CORONOIDECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

4. An operative report shall be submitted for payment.

PROCEDURE D7995
SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7996
IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT

This procedure is not a benefit.

PROCEDURE D7997
APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. A benefit:
   a. once per arch per date of service.
   b. for the removal of appliances related to surgical procedures only.
5. Not a benefit for the removal of orthodontic appliances and space maintainers.

PROCEDURE D7998
INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE

This procedure is not a benefit.

PROCEDURE D7999
UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT

1. Radiographs for payment – submit radiographs if applicable for the type of procedure.
2. Photographs for payment – submit photographs if applicable for the type of procedure.
3. Written documentation or operative report– describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
4. Procedure D7999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.

   Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Orthodontic General Policies (D8000-D8999)

1. Orthodontic Procedures (D8080, D8660, D8670 and D8680)
   A) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
   B) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
   C) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
   D) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
   E) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
   F) The automatic qualifying conditions are:
      i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
      iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
      v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
      vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
   G) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:
      i) when the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or
      ii) when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.
   H) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.
   I) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.
   J) If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.

K) If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

Orthodontic Procedures (D8000-D8999)

PROCEDURE D8010
LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This procedure is not a benefit.

PROCEDURE D8020
LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8030
LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

This procedure is not a benefit.

PROCEDURE D8040
LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION

This procedure is not a benefit.

PROCEDURE D8050
INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This procedure is not a benefit.

PROCEDURE D8060
INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8070
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8080
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

1. Prior authorization is required. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470), and
   e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
2. No treatment will be authorized and no payment will be allowed after the month of the patient's 21st birthday.
3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or
   b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.
4. A benefit:
   a. for handicapping malocclusion, cleft palate and facial growth management cases.
   b. for patients under the age of 21.
   c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. once per patient per phase of treatment.
5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.

PROCEDURE D8090
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION

This procedure is not a benefit.

PROCEDURE D8210
REMOVABLE APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8220
FIXED APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8660
PRE-ORTHODONTIC TREATMENT VISIT

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.
2. Prior authorization is required. The following shall be submitted together for authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. pre-orthodontic treatment visit(s) (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and
   c. periodic orthodontic treatment visit(s) (D8670), and
   d. orthodontic retention (D8680), and
   e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
3. Written documentation for prior authorization- shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.
4. A benefit:
   a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.
   b. once every three months.
   c. for patients under the age of 21.
   d. for a maximum of six.

PROCEDURE D8670
PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).
3. A benefit:
   a. for patients under the age of 21.
   b. for permanent dentition (unless the patient is age 13 or older with primary

teeth still present or has a cleft palate or craniofacial anomaly).

c. once per calendar quarter.

4. The maximum quantity of monthly treatment visits for the following phases are:
   a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
   b. Cleft Palate:
      i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
   c. Facial Growth Management:
      i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

PROCEDURE D8680
ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per arch for each authorized phase of orthodontic treatment.
5. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
6. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

PROCEDURE D8690
ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO A CONTRACT FEE)

This procedure is not a benefit.

PROCEDURE D8691
REPAIR OF ORTHODONTIC APPLIANCE

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8692
REPLACEMENT OF LOST OR BROKEN RETAINER

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. once per arch.
   c. only within 24 months following the date of service of orthodontic retention (D8680).
5. This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

PROCEDURE D8693
REBONDING OR RECEMENTING: AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8999
UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment-submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment-submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 21.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.
7. Procedure D8999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adjunctive General Policies (D9000-D9999)

1. Anesthesia (D9210-D9248)
2. General anesthesia (D9220 and D9221) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.
3. Intravenous sedation/analgesia (D9241 and D9242) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.
4. Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.
5. Deep sedation/general anesthesia (D9220 and D9221) and intravenous conscious sedation/analgesia (D9241 and D9242) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include the following:
   A) a severe mental or physical handicap,
   B) extensive surgical procedures,
   C) an uncooperative child,
   D) an acute infection at an injection site,
   E) a failure of a local anesthetic to control pain.
6. The administration of deep sedation/general anesthesia (D9220 and D9221), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied.
7. Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:
   A) Procedure D9220/D9221 (Deep Sedation/General Anesthesia),
   B) Procedure D9241/D9242 (Intravenous Conscious Sedation/Analgesia),
   C) Procedure D9248 (Non-Intravenous Conscious Sedation),
   D) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis).
8. Providers who administer general anesthesia (D9220 and D9221) and/or intravenous conscious sedation/analgesia (D9241 and D9242) shall have valid anesthesia permits with the California Dental Board.
9. The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/ anesthetic procedure.
10. Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.
11. Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

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Adjunctive Service Procedures (D9000-D9999)

PROCEDURE D9110
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/area, condition and specific treatment performed.
3. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9120
FIXED PARTIAL DENTURE SECTIONING

1. This procedure does not require prior authorization.
2. Radiographs for payment-submit pre-operative radiographs.
3. Requires a tooth code for the retained tooth.
4. A benefit when at least one of the abutment teeth is to be retained.

PROCEDURE D9210
LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the medical necessity for the local anesthetic injection.
3. A benefit:
   a. once per date of service per provider.
   b. only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9211
REGIONAL BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9212
TRIGEMINAL DIVISION BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9215
LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9220
PROCEDURE DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. The anesthetic induction agent shall also be documented.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. Not a benefit:
   a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9221
PROCEDURE DEEP SEDATION/GENERAL ANESTHESIA – EACH ADDITIONAL 15 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a

mental or physical limitation or contraindication to a local anesthetic agent. The anesthetic induction agent shall also be documented.

3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
   a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9230
INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
3. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
4. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9241
INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – FIRST 30 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9242
INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – EACH ADDITIONAL 15 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of

nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9248
NON-INTRAVENOUS CONSCIOUS SEDATION

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients of all ages- shall indicate the specific anesthetic agent administered and the method of administration.
3. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
4. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
   c. for oral, patch, intramuscular or subcutaneous routes of administration.
   d. once per date of service.
5. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9241 and D9242).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9310
CONSULTATION - (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN

This procedure shall only be billed as diagnostic procedures D0120, D0140, D0150, or D0160.

PROCEDURE D9410
HOUSE/EXTENDED CARE FACILITY CALL

1. Written documentation for payment – shall include the name, phone number, and address of the facility. When requesting treatment for a patient who cannot leave their private residence due to a medical condition, the patient's physician shall submit a letter on their professional letterhead with the following information documented:
   a. the patient's specific medical condition, and
   b. the reason why the patient cannot leave their private residence, and
   c. the length of time the patient will be homebound.
2. A benefit:
   a. once per patient per date of service.
   b. only in conjunction with procedures that are payable.
3. When this procedure is submitted for payment without associated procedures, the medical necessity for the visit shall be documented and justified.

PROCEDURE D9420
HOSPITAL OR AMBULATORY SURGICAL CENTER CALL

1. The operative report for payment – shall include the total time in the operating room or ambulatory surgical center.
2. A benefit for each hour or fraction thereof as documented on the operative report.
3. Not a benefit:
   a. for an assistant surgeon.
   b. for time spent compiling the patient history, writing reports or for post-operative or follow up visits.

PROCEDURE D9430
OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO OTHER SERVICES PERFORMED

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the

tooth/area, the chief complaint and the non-clinical treatment taken.

3. A benefit once per date of service per provider.
4. Not a benefit:
   a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service.
   b. for visits to patients residing in a house/extended care facility.

PROCEDURE D9440
OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include justification of the emergency (chief complaint) and be specific to an area or tooth. The time and day of the week shall also be documented.
3. A benefit
   a. once per date of service per provider.
   b. only with treatment that is a benefit.
4. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

PROCEDURE D9450
CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING

This procedure is not a benefit.

PROCEDURE D9610
THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION

1. Written documentation for payment – shall include the specific drug name and classification.
2. A benefit for up to a maximum of four injections per date of service.
3. Not a benefit:
   a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9612
THERAPEUTIC PARENTERAL DRUG, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS

This procedure can only be billed as therapeutic parenteral drug, single administration (D9610).

PROCEDURE D9630
OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT

This procedure is not a benefit.

PROCEDURE D9910
APPLICATION OF DESENSITIZING MEDICAMENT

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/teeth and the specific treatment performed.
3. A benefit:
   a. once in a 12-month period per provider.
   b. for permanent teeth only.
4. Not a benefit:
   a. when used as a base, liner or adhesive under a restoration.
   b. the same date of service as fluoride (D1206 and D1208).

PROCEDURE D9911
APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D9920
BEHAVIOR MANAGEMENT, BY REPORT

This procedure is not a benefit.

PROCEDURE D9930
TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES, BY REPORT

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth, condition and specific treatment performed.
3. Requires a tooth code.
4. A benefit:

   a. once per date of service per provider.
   b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.
   c. for the removal of bony fragments within 30 days of the date of service of an extraction.
5. Not a benefit:
   a. for the removal of bony fragments on the same date of service as an extraction.
   b. for routine post-operative visits.

PROCEDURE D9940
OCCLUSAL GUARD, BY REPORT

This procedure is not a benefit.

PROCEDURE D9941
FABRICATION OF ATHLETIC MOUTHGUARD

This procedure is not a benefit.

PROCEDURE D9942
REPAIR AND/OR RELINE OF OCCLUSAL GUARD

This procedure is not a benefit.

PROCEDURE D9950
OCCLUSION ANALYSIS – MOUNTED CASE

1. Prior authorization is required.
2. Written documentation for prior authorization – shall describe the specific symptoms with a detailed history and diagnosis.
3. A benefit:
   a. once in a 12-month period.
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
4. Not a benefit for bruxism only.
5. The fee for this procedure includes face bow, interocclusal record tracings, diagnostic wax up and diagnostic casts.

PROCEDURE D9951
OCCLUSAL ADJUSTMENT - LIMITED

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a quadrant code.
3. A benefit:
   a. once in a 12-month period per quadrant per provider.
   b. for patients age 13 or older.
   c. for natural teeth only.
4. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

PROCEDURE D9952
OCCLUSAL ADJUSTMENT - COMPLETE

1. Prior authorization is required.
2. Written documentation for prior authorization – submit interocclusal record tracings that demonstrate the medical necessity to eliminate destructive occlusal forces.
3. A benefit:
   a. once in a 12-month period following occlusion analysis-mounted case (D9950).
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
4. Not a benefit in conjunction with an occlusal orthotic device (D7880).
5. Occlusion analysis-mounted case (D9950) must precede this procedure.

PROCEDURE D9970
ENAMEL MICROABRASION

This procedure is not a benefit.

PROCEDURE D9971
ODONTOPLASTY 1 – 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS

This procedure is not a benefit.

PROCEDURE D9972
EXTERNAL BLEACHING – PER ARCH - PERFORMED IN OFFICE

This procedure is not a benefit.

PROCEDURE D9973
EXTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

PROCEDURE D9974
INTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

PROCEDURE D9975
EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH; INCLUDES MATERIALS AND FABRICATION OF CUSTOM TRAYS

This procedure is not a benefit.

PROCEDURE D9999
UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – shall include a full description of the proposed or actual treatment and the medical necessity.
5. Procedure D9999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Denti-Cal Schedule of Maximum Allowances

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
    a. provider's billed amount
    b. the maximum allowance set forth in the schedule below
2. Refer to your Medi-Cal Dental Program Provider Handbook for specific procedure instructions and program limitations.

Benefit: Dental or medical health care services covered by the Medi-Cal program

Not a Benefit: Dental or medical health care services not covered by the Medi-Cal program

Global: Treatment performed in conjunction with another procedure which is not payable separately

By Report: Payment amount determined from submitted documentation.

CDT Codes	Procedure Code Description	Maximum $$ Allowance
Diagnostic		
D0120	Periodic oral evaluation - established patient	$15.00
D0140	Limited oral evaluation – problem focused	$35.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Global
D0150	Comprehensive oral evaluation – new or established patient	$25.00
D0160	Detailed and extensive oral evaluation – problem focused, by report	$100.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$75.00
D0180	Comprehensive periodontal evaluation – new or established patient	Global
D0190	Screening of a patient	Not A Benefit
D0191	Assessment of a patient	Not A Benefit
D0210	Intraoral - complete series of radiographic images	$40.00
D0220	Intraoral - periapical first radiographic image	$10.00
D0230	Intraoral - periapical each additional radiographic image	$3.00
D0240	Intraoral - occlusal radiographic image	$10.00
D0250	Extraoral - first radiographic image	$22.00
D0260	Extraoral - each additional radiographic image	$5.00
D0270	Bitewing - single radiographic image	$5.00
D0272	Bitewings - two radiographic images	$10.00
D0273	Bitewings - three radiographic images	Global
D0274	Bitewings - four radiographic images	$18.00
D0277	Vertical bitewings - 7 to 8 radiographic images	Global
D0290	Posterior - anterior or lateral skull and facila bone survey radiographic image	$35.00
D0310	Sialography	$100.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D0320	Temporomandibular joint arthrogram, including injection	$76.00
D0321	Other temporomandibular joint radiographic images, by report	Not A Benefit
D0322	Tomographic survey	$100.00
D0330	Panoramic radiographic image	$25.00
D0340	Cephalometric radiographic image	$50.00
D0350	Oral/Facial photographic images	$6.00
D0363	Cone beam - three dimensional image reconstruction using existing data, includes multiple images	Not A Benefit
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Not A Benefit
D0365	Cone beam CT capture and interpretation with limited field of view of one full dental arch - mandible	Not A Benefit
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Not A Benefit
D0367	Cone beam CT capture and interpretation with field of view of both jaws with or without cranium	Not A Benefit
D0368	Cone beam CT capture and interpretation for tmj series including two or more exposures	Not A Benefit
D0369	Maxillofacial MRI capture and interpretation	Not A Benefit
D0370	Maxillofacial ultrasound capture and interpretation	Not A Benefit
D0371	Sialoendoscopy capture and interpretation	Not A Benefit
D0380	Cone beam CT image capture with limited field of view - less than one whole jaw	Not A Benefit
D0381	Cone beam CT image capture with field of view of one full dental arch - mandible	Not A Benefit
D0382	Cone beam CT image capture with field of view of one full dental arch - maxilla with or without cranium	Not A Benefit
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	Not A Benefit
D0384	Cone beam CT image capture for TMJ series including two or more exposures	Not A Benefit
D0385	Maxillofacial MRI image capture	Not A Benefit
D0386	Maxillofacial ultrasound image capture	Not A Benefit
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Not A Benefit
D0415	Collection of microorganisms for culture and sensitivity	Not A Benefit
D0416	Viral Culture	Not A Benefit
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Not A Benefit
D0418	Analysis of saliva sample	Not A Benefit
D0421	Genetic test for susceptibility to oral diseases	Not A Benefit
D0425	Caries susceptibility tests	Not A Benefit

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not A Benefit
D0460	Pulp vitality tests	Global
D0470	Diagnostic casts	$75.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not A Benefit
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not A Benefit
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not A Benefit
D0475	Decalcification procedure	Not A Benefit
D0476	Special stains for microorganisms	Not A Benefit
D0477	Special stains not for microorganisms	Not A Benefit
D0478	Immunohistochemical stains	Not A Benefit
D0479	Tissue in-situ hybridization, including interpretation	Not A Benefit
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Not A Benefit
D0481	Electron microscopy	Not A Benefit
D0482	Direct immunofluorescence	Not A Benefit
D0483	Indirect immunofluorescence	Not A Benefit
D0484	Consultation on slides prepared elsewhere	Not A Benefit
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Not A Benefit
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Not A Benefit
D0502	Other oral pathology procedures, by report	By Report
D0999	Unspecified diagnostic procedure, by report	$46.00
Preventive		
D1110	Prophylaxis – adult	$40.00
D1120	Prophylaxis – child	$30.00
D1206	Topical application of fluoride varnish - child 0 to 5	$18.00
D1206	Topical application of fluoride varnish - child 6 to 20	$8.00
D1206	Topical application of fluoride varnish - adult 21 and over	$6.00
D1208	Topical application of fluoride - child 0-5	$18.00
D1208	Topical application of fluoride - child 6-20	$8.00
D1208	Topical application of fluoride - adult	$6.00
D1310	Nutritional counseling for control of dental disease	Global

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D1320	Tobacco counseling for the control and prevention of oral disease	Global
D1330	Oral hygiene instructions	Global
D1351	Sealant – per tooth	$22.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$22.00
D1510	Space maintainer-fixed – unilateral	$120.00
D1515	Space maintainer-fixed – bilateral	$200.00
D1520	Space maintainer-removable – unilateral	$230.00
D1525	Space maintainer-removable – bilateral	$230.00
D1550	Re-cementation of space maintainer	$30.00
D1555	Removal of fixed space maintainer	$30.00
Restorative		
D2140	Amalgam – one surface, primary or permanent	$39.00
D2150	Amalgam – two surfaces, primary or permanent	$48.00
D2160	Amalgam – three surfaces, primary or permanent	$57.00
D2161	Amalgam – four or more surfaces, primary or permanent	$60.00
D2330	Resin-based composite – one surface, anterior	$55.00
D2331	Resin-based composite – two surfaces, anterior	$60.00
D2332	Resin-based composite – three surfaces, anterior	$65.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$85.00
D2390	Resin-based composite crown, anterior	$75.00
D2391	Resin-based composite – one surface, posterior	$39.00
D2392	Resin-based composite – two surfaces, posterior	$48.00
D2393	Resin-based composite – three surfaces, posterior	$57.00
D2394	Resin-based composite – four or more surfaces, posterior	$60.00
D2410	Gold foil – one surface	Not A Benefit
D2420	Gold foil – two surfaces	Not A Benefit
D2430	Gold foil – three surfaces	Not A Benefit
D2510	Inlay – metallic – one surface	Not A Benefit
D2520	Inlay – metallic – two surfaces	Not A Benefit
D2530	Inlay – metallic – three surfaces	Not A Benefit
D2542	Onlay – metallic – two surfaces	Not A Benefit
D2543	Onlay – metallic – three surfaces	Not A Benefit
D2544	Onlay – metallic – four or more surfaces	Not A Benefit
D2610	Inlay – porcelain/ceramic – one surface	Not A Benefit
D2620	Inlay – porcelain/ceramic – two surfaces	Not A Benefit

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D2630	Inlay – porcelain/ceramic – three or more surfaces	Not A Benefit
D2642	Onlay – porcelain/ceramic – two surfaces	Not A Benefit
D2643	Onlay – porcelain/ceramic – three surfaces	Not A Benefit
D2644	Onlay – porcelain/ceramic – four or more surfaces	Not A Benefit
D2650	Inlay – resin-based composite – one surface	Not A Benefit
D2651	Inlay – resin-based composite – two surfaces	Not A Benefit
D2652	Inlay – resin-based composite – three or more surfaces	Not A Benefit
D2662	Onlay – resin-based composite – two surfaces	Not A Benefit
D2663	Onlay – resin-based composite – three surfaces	Not A Benefit
D2664	Onlay – resin-based composite – four or more surfaces	Not A Benefit
D2710	Crown – resin - based composite (indirect)	$150.00
D2712	Crown - 3/4 resin-based composite (indirect)	$150.00
D2720	Crown – resin with high noble metal	Not A Benefit
D2721	Crown – resin with predominantly base metal	$220.00
D2722	Crown – resin with noble metal	Not A Benefit
D2740	Crown – porcelain/ceramic substrate	$340.00
D2750	Crown – porcelain fused to high noble metal	Not A Benefit
D2751	Crown – porcelain fused to predominantly base metal	$340.00
D2752	Crown – porcelain fused to noble metal	Not A Benefit
D2780	Crown – 3/4 cast high noble metal	Not A Benefit
D2781	Crown – 3/4 cast predominantly base metal	$340.00
D2782	Crown – 3/4 cast noble metal	Not A Benefit
D2783	Crown – 3/4 porcelain/ceramic	$340.00
D2790	Crown – full cast high noble metal	Not A Benefit
D2791	Crown – full cast predominantly base metal	$340.00
D2792	Crown – full cast noble metal	Not A Benefit
D2794	Crown - titanium	Not A Benefit
D2799	Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	Not A Benefit
D2910	Recement inlay, onlay, or partial coverage restoration	$30.00
D2915	Recement cast or prefabricated post and core	Global
D2920	Recement crown	$30.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$75.00
D2930	Prefabricated stainless steel crown – primary tooth	$75.00
D2931	Prefabricated stainless steel crown – permanent tooth	$90.00
D2932	Prefabricated resin crown	$75.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D2933	Prefabricated stainless steel crown with resin window	$75.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	Not A Benefit
D2940	Protective restoration	$45.00
D2950	Core buildup, including any pins	Global
D2951	Pin retention – per tooth, in addition to restoration	$80.00
D2952	Post and core in addition to crown, indirectly fabricated	$75.00
D2953	Each additional indirectly fabricated post – same tooth	Global
D2954	Prefabricated post and core in addition to crown	$75.00
D2955	Post removal	Global
D2957	Each additional prefabricated post -same tooth	Global
D2960	Labial veneer (resin laminate) – chairside	Not A Benefit
D2961	Labial veneer (resin laminate) – laboratory	Not A Benefit
D2962	Labial veneer (porcelain laminate) – laboratory	Not A Benefit
D2970	Temporary crown (fractured tooth)	$45.00
D2971	Additional procedures to construct new crown under existing partial denture framework	Global
D2975	Coping	Not A Benefit
D2980	Crown repair, necessitated by restorative material failure	$60.00
D2981	Inlay repair necessitated by restorative material failure	Not A Benefit
D2982	Onlay repair necessitated by restorative material failure	Not A Benefit
D2983	Veneer repair necessitated by restorative material failure	Not A Benefit
D2990	Resin infiltration of incipient smooth surface lesions	Not A Benefit
D2999	Unspecified restorative procedure, by report	$50.00
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	Global
D3120	Pulp cap – indirect (excluding final restoration)	Global
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament	$71.00
D3221	Pulpal debridement, primary and permanent teeth	$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$71.00
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$71.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$71.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$216.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$261.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$331.00
D3331	Treatment of root canal obstruction; non-surgical access	Global
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not A Benefit
D3333	Internal root repair of perforation defects	Global
D3346	Retreatment of previous root canal therapy – anterior	$216.00
D3347	Retreatment of previous root canal therapy – bicuspid	$261.00
D3348	Retreatment of previous root canal therapy – molar	$331.00
D3351	Apexification/Recalcification/Pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.)	$100.00
D3352	Apexification/Recalcification/Pulpal regeneration - interim medication replacement	$100.00
D3353	Apexification/Recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Not A Benefit
D3354	Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	Not A Benefit
D3410	Apicoectomy/Periradicular surgery – anterior	$100.00
D3421	Apicoectomy/Periradicular surgery – bicuspid (first root)	$100.00
D3425	Apicoectomy/Periradicular surgery – molar (first root)	$100.00
D3426	Apicoectomy/Periradicular surgery – (each additional root)	$100.00
D3430	Retrograde filling – per root	Global
D3450	Root amputation – per root	Not A Benefit
D3460	Endodontic endosseous implant	Not A Benefit
D3470	Intentional reimplantation (including necessary splinting)	Not A Benefit
D3910	Surgical procedure for isolation of tooth with rubber dam	Global
D3920	Hemisection (including any root removal), not including root canal therapy	Not A Benefit
D3950	Canal preparation and fitting of preformed dowel or post	Not A Benefit
D3999	Unspecified endodontic procedure, by report	$42.00
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bound spaces per quadrant	$185.00
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$110.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not A Benefit
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Not A Benefit
D4231	Anatomical crown exposure - one to three teeth per quadrant	Not A Benefit
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	Not A Benefit
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	Not A Benefit

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D4245	Apically positioned flap	Not A Benefit
D4249	Clinical crown lengthening – hard tissue	Global
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant	$245.00
D4263	Bone replacement graft – first site in quadrant	Not A Benefit
D4264	Bone replacement graft – each additional site in quadrant	Not A Benefit
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Global
D4266	Guided tissue regeneration – resorbable barrier, per site	Not A Benefit
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	Not A Benefit
D4268	Surgical revision procedure, per tooth	Not A Benefit
D4270	Pedicle soft tissue graft procedure	Not A Benefit
D4273	Subepithelial connective tissue graft procedures, per tooth	Not A Benefit
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not A Benefit
D4275	Soft tissue allograft	Not A Benefit
D4276	Combined connective tissue and double pedicle graft, per tooth	Not A Benefit
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	Not A Benefit
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	Not A Benefit
D4320	Provisional splinting – intracoronal	Not A Benefit
D4321	Provisional splinting – extracoronal	Not A Benefit
D4341	Periodontal scaling and root planing – four or more teeth per quadrant (for beneficiaries in a SNF or ICF)	$70.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant (for beneficiaries in a SNF or ICF)	$50.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Global
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Global
D4910	Periodontal maintenance	$130.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$45.00
D4999	Unspecified periodontal procedure, by report	By Report

CDT Codes	Procedure Code Description	Maximum $$ Allowance
Prosthodontics (Removable)		
D5110	Complete denture – maxillary	$450.00
D5120	Complete denture – mandibular	$450.00
D5130	Immediate denture – maxillary	$450.00
D5140	Immediate denture – mandibular	$450.00
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$250.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rest and teeth)	$250.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	$470.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	$470.00
D5225	Maxillary partial denture - flexible base (including any conventional clasps, rests, and teeth)	Not A Benefit
D5226	Mandibular partial denture - flexible base (including any conventional clasps, rests, and teeth)	Not A Benefit
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	Not A Benefit
D5410	Adjust complete denture – maxillary	$25.00
D5411	Adjust complete denture – mandibular	$25.00
D5421	Adjust partial denture – maxillary	$25.00
D5422	Adjust partial denture – mandibular	$25.00
D5510	Repair broken complete denture base	$50.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	$50.00
D5610	Repair resin denture base	$60.00
D5620	Repair cast framework	$230.00
D5630	Repair or replace broken clasp	$100.00
D5640	Replace broken teeth – per tooth	$50.00
D5650	Add tooth to existing partial denture	$60.00
D5660	Add clasp to existing partial denture	$100.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not A Benefit
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not A Benefit
D5710	Rebase complete maxillary denture	Not A Benefit
D5711	Rebase complete mandibular denture	Not A Benefit
D5720	Rebase maxillary partial denture	Not A Benefit
D5721	Rebase mandibular partial denture	Not A Benefit
D5730	Reline complete maxillary denture (chairside)	$70.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D5731	Reline complete mandibular denture (chairside)	$70.00
D5740	Reline maxillary partial denture (chairside)	$70.00
D5741	Reline mandibular partial denture (chairside)	$70.00
D5750	Reline complete maxillary denture (laboratory)	$140.00
D5751	Reline complete mandibular denture (laboratory)	$140.00
D5760	Reline maxillary partial denture (laboratory)	$140.00
D5761	Reline mandibular partial denture (laboratory)	$140.00
D5810	Interim complete denture (maxillary)	Not A Benefit
D5811	Interim complete denture (mandibular)	Not A Benefit
D5820	Interim partial denture (maxillary)	Not A Benefit
D5821	Interim partial denture (mandibular)	Not A Benefit
D5850	Tissue conditioning, maxillary	$50.00
D5851	Tissue conditioning, mandibular	$50.00
D5860	Overdenture – complete, by report	$450.00
D5861	Overdenture – partial, by report	Not A Benefit
D5862	Precision attachment, by report	Global
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Not A Benefit
D5875	Modification of removable prosthesis following implant surgery	Not A Benefit
D5899	Unspecified removable prosthodontic procedure, by report	By Report
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	$425.00
D5912	Facial moulage (complete)	$534.00
D5913	Nasal prosthesis	$1,200.00
D5914	Auricular prosthesis	$1,200.00
D5915	Orbital prosthesis	$600.00
D5916	Ocular prosthesis	$1,200.00
D5919	Facial prosthesis	$1,200.00
D5922	Nasal septal prosthesis	$600.00
D5923	Ocular prosthesis, interim	$600.00
D5924	Cranial prosthesis	$1,400.00
D5925	Facial augmentation implant prosthesis	$300.00
D5926	Nasal prosthesis, replacement	$300.00
D5927	Auricular prosthesis, replacement	$300.00
D5928	Orbital prosthesis, replacement	$300.00
D5929	Facial prosthesis, replacement	$300.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D5931	Obturator prosthesis, surgical	$1,000.00
D5932	Obturator prosthesis, definitive	$1,500.00
D5933	Obturator prosthesis, modification	$225.00
D5934	Mandibular resection prosthesis with guide flange	$1,700.00
D5935	Mandibular resection prosthesis without guide flange	$1,400.00
D5936	Obturator prosthesis, interim	$900.00
D5937	Trismus appliance (not for TMD treatment)	$125.00
D5951	Feeding aid	$200.00
D5952	Speech aid prosthesis, pediatric	$800.00
D5953	Speech aid prosthesis, adult	$1,450.00
D5954	Palatal augmentation prosthesis	$200.00
D5955	Palatal lift prosthesis, definitive	$1,400.00
D5958	Palatal lift prosthesis, interim	$800.00
D5959	Palatal lift prosthesis, modification	$220.00
D5960	Speech aid prosthesis, modification	$220.00
D5982	Surgical stent	$125.00
D5983	Radiation carrier	$80.00
D5984	Radiation shield	$200.00
D5985	Radiation cone locator	$200.00
D5986	Fluoride gel carrier	$80.00
D5987	Commissure splint	$125.00
D5988	Surgical splint	$205.00
D5991	Topical Medicament Carrier	$80.00
D5992	Adjust maxillofacial prosthetic appliance, by report	Not A Benefit
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Not A Benefit
D5999	Unspecified maxillofacial prosthesis, by report	By Report
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	By Report
D6040	Surgical placement: eposteal implant	By Report
D6050	Surgical placement: transosteal implant	By Report
D6051	Interim abutment	Not A Benefit
D6053	Implant/Abutment supported removable denture for completely edentulous arch	By Report
D6054	Implant/Abutment supported removable denture for partially edentulous arch	By Report
D6055	Connecting bar - implant supported or abutment supported	By Report
D6056	Prefabricated abutment - includes modification and placement	By Report

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D6057	Custom fabricated abutment - includes placement	By Report
D6058	Abutment supported porcelain/ceramic crown	By Report
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	By Report
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	By Report
D6061	Abutment supported porcelain fused to metal crown (noble metal)	By Report
D6062	Abutment supported cast metal crown (high noble metal)	By Report
D6063	Abutment supported cast metal crown (predominantly base metal)	By Report
D6064	Abutment supported cast metal crown (noble metal)	By Report
D6065	Implant supported porcelain/ceramic crown	By Report
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	By Report
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	By Report
D6068	Abutment supported retainer for porcelain/ceramic FPD	By Report
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	By Report
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	By Report
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	By Report
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	By Report
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	By Report
D6074	Abutment supported retainer for cast metal FPD (noble metal)	By Report
D6075	Implant supported retainer for ceramic FPD	By Report
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6077	Implantsupported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6078	Implant/Abutment supported fixed denture for completely edentulous arch	By Report
D6079	Implant/Abutment supported fixed denture for partially edentulous arch	By Report
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	By Report
D6090	Repair implant supported prosthesis, by report	By Report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	By Report
D6092	Recement implant/abutment supported crown	$30.00
D6093	Recement implant/abutment supported fixed partial denture	$50.00
D6094	Abutment supported crown (titanium)	By Report
D6095	Repair implant abutment, by report	By Report
D6100	Implant removal, by report	$45.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant services, including flap entry and closure	Not A Benefit
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	Not A Benefit
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not A Benefit
D6104	Bone graft at time of implant placement	Not A Benefit
D6190	Radiographic/Surgical implant index, by report	Global
D6194	Abutment supported retainer crown for FPD (titanium)	By Report
D6199	Unspecified implant procedure, by report	By Report
Fixed Prosthodontics		
D6205	Pontic - indirect resin based composite	Not A Benefit
D6210	Pontic – cast high noble metal	Not A Benefit
D6211	Pontic – cast predominantly base metal	$325.00
D6212	Pontic – cast noble metal	Not A Benefit
D6214	Pontic - titanium	Not A Benefit
D6240	Pontic – porcelain fused to high noble metal	Not A Benefit
D6241	Pontic – porcelain fused to predominantly base metal	$325.00
D6242	Pontic – porcelain fused to noble metal	Not A Benefit
D6245	Pontic –porcelain/ceramic	$325.00
D6250	Pontic – resin with high noble metal	Not A Benefit
D6251	Pontic – resin with predominantly base metal	$325.00
D6252	Pontic – resin with noble metal	Not A Benefit
D6253	Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	Not A Benefit
D6545	Retainer – cast metal for resin bonded fixed prosthesis	Not A Benefit
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	Not A Benefit
D6600	Inlay – porcelain/ceramic, two surfaces	Not A Benefit
D6601	Inlay – porcelain/ceramic, three or more surfaces	Not A Benefit
D6602	Inlay – cast high noble metal, two surfaces	Not A Benefit
D6603	Inlay – cast high noble metal, three or more surfaces	Not A Benefit
D6604	Inlay – cast predominantly base metal, two surfaces	Not A Benefit
D6605	Inlay – cast predominantly base metal, three or more surfaces	Not A Benefit
D6606	Inlay – cast noble metal, two surfaces	Not A Benefit
D6607	Inlay – cast noble metal, three or more surfaces	Not A Benefit
D6608	Onlay – porcelain/ceramic, two surfaces	Not A Benefit

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D6609	Onlay – porcelain/ceramic, three or more surfaces	Not A Benefit
D6610	Onlay – cast high noble metal, two surfaces	Not A Benefit
D6611	Onlay – cast high noble metal, three or more surfaces	Not A Benefit
D6612	Onlay – cast predominantly base metal, two surfaces	Not A Benefit
D6613	Onlay – cast predominantly base metal, three or more surfaces	Not A Benefit
D6614	Onlay – cast noble metal, two surfaces	Not A Benefit
D6615	Onlay – cast noble metal, three or more surfaces	Not A Benefit
D6624	Inlay - titanium	Not A Benefit
D6634	Onlay - titanium	Not A Benefit
D6710	Crown - indirect resin based composite	Not A Benefit
D6720	Crown – resin with high noble metal	Not A Benefit
D6721	Crown – resin with predominantly base metal	$220.00
D6722	Crown – resin with noble metal	Not A Benefit
D6740	Crown – porcelain/ceramic	$340.00
D6750	Crown – porcelain fused to high noble metal	Not A Benefit
D6751	Crown – porcelain fused to predominantly base metal	$340.00
D6752	Crown – porcelain fused to noble metal	Not A Benefit
D6780	Crown – 3/4 cast high noble metal	Not A Benefit
D6781	Crown – 3/4 cast predominantly base metal	$340.00
D6782	Crown – 3/4 cast noble metal	Not A Benefit
D6783	Crown – 3/4 porcelain/ceramic	$340.00
D6790	Crown – full cast high noble metal	Not A Benefit
D6791	Crown – full cast predominantly base metal	$340.00
D6792	Crown – full cast noble metal	Not A Benefit
D6793	Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	Not A Benefit
D6794	Crown - titanium	Not A Benefit
D6920	Connector bar	Not A Benefit
D6930	Recement fixed partial denture	$50.00
D6940	Stress breaker	Not A Benefit
D6950	Precision attachment	Not A Benefit
D6975	Coping	Not A Benefit
D6980	Fixed partial denture repair, necessitated by restorative material failure	$75.00
D6985	Pediatric partial denture, fixed	Not A Benefit
D6999	Unspecified fixed prosthodontic procedure, by report	By Report

CDT Codes	Procedure Code Description	Maximum $$ Allowance
Oral and Maxillofacial Surgery		
D7111	Extraction, coronal remnants – deciduous tooth	$41.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$41.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$85.00
D7220	Removal of impacted tooth – soft tissue	$100.00
D7230	Removal of impacted tooth – partially bony	$135.00
D7240	Removal of impacted tooth – completely bony	$165.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$235.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$100.00
D7251	Coronectomy - intentional partial tooth removal	Not A Benefit
D7260	Oroantral fistula closure	$300.00
D7261	Primary closure of a sinus perforation	$100.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$175.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not A Benefit
D7280	Surgical access of an unerupted tooth	$100.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not A Benefit
D7283	Placement of device to facilitate eruption of impacted tooth	$135.00
D7285	Biopsy of oral tissue – hard (bone, tooth)	$100.00
D7286	Biopsy of oral tissue – soft	$30.00
D7287	Exfoliative cytological sample collection	Not A Benefit
D7288	Brush biopsy - transepithelial sample collection	Not A Benefit
D7290	Surgical repositioning of teeth	$135.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$50.00
D7292	Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap	Not A Benefit
D7293	Surgical placement: temporary anchorage device requiring surgical flap	Not A Benefit
D7294	Surgical placement: temporary anchorage device without surgical flap	Not A Benefit
D7295	Harvest of bone for use in autogenous grafting procedure	Not A Benefit
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Global
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per qaudrant	Global

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$200.00
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$500.00
D7410	Excision of benign lesion up to 1.25 cm	$100.00
D7411	Excision of benign lesion greater than 1.25 cm	$250.00
D7412	Excision of benign lesion, complicated	$325.00
D7413	Excision of malignant lesion up to 1.25 cm	$325.00
D7414	Excision of malignant lesion greater than 1.25 cm	$400.00
D7415	Excision of malignant lesion, complicated	$450.00
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$325.00
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$500.00
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$100.00
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$200.00
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$100.00
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250.00
D7465	Destruction of lesion(s) by physical or chemical method, by report	$50.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$100.00
D7472	Removal of torus palatinus	$200.00
D7473	Removal of torus mandibularis	$100.00
D7485	Surgical reduction of osseous tuberosity	$75.00
D7490	Radical resection of maxilla or mandible	$1,200.00
D7510	Incision and drainage of abscess – intraoral soft tissue	$50.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$75.00
D7520	Incision and drainage of abscess – extraoral soft tissue	$75.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$100.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$60.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$130.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$100.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$380.00
D7610	Maxilla – open reduction (teeth immobilized, if present)	$1,000.00
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$500.00
D7630	Mandible – open reduction (teeth immobilized, if present)	$1,200.00
D7640	Mandible – closed reduction (teeth immobilized, if present)	$700.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D7650	Malar and/or zygomatic arch – open reduction	$500.00
D7660	Malar and/or zygomatic arch – closed reduction	$250.00
D7670	Alveolus – closed reduction, may include stabilization of teeth	$225.00
D7671	Alveolus – open reduction, may include stabilization of teeth	$275.00
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	By Report
D7710	Maxilla – open reduction	$1,200.00
D7720	Maxilla – closed reduction	$800.00
D7730	Mandible – open reduction	$1,200.00
D7740	Mandible – closed reduction	$800.00
D7750	Malar and/or zygomatic arch – open reduction	$500.00
D7760	Malar and/or zygomatic arch – closed reduction	$250.00
D7770	Alveolus – open reduction stabilization of teeth	$1,000.00
D7771	Alveolus, closed reduction stabilization of teeth	$500.00
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	By Report
D7810	Open reduction of dislocation	$140.00
D7820	Closed reduction of dislocation	$140.00
D7830	Manipulation under anesthesia	$140.00
D7840	Condylectomy	$1,000.00
D7850	Surgical discectomy, with/without implant	$1,000.00
D7852	Disc repair	$780.00
D7854	Synovectomy	$800.00
D7856	Myotomy	$810.00
D7858	Joint reconstruction	$1,550.00
D7860	Arthrostomy	$940.00
D7865	Arthroplasty	$1,100.00
D7870	Arthrocentesis	$440.00
D7871	Non-arthroscopic lysis and lavage	Global
D7872	Arthroscopy – diagnosis, with or without biopsy	$800.00
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$800.00
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$800.00
D7875	Arthroscopy – surgical: synovectomy	$800.00
D7876	Arthroscopy – surgical: discectomy	$1,000.00
D7877	Arthroscopy – surgical: debridement	$800.00
D7880	Occlusal orthotic device, by report	$300.00
D7899	Unspecified TMD therapy, by report	By Report

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D7910	Suture of recent small wounds up to 5 cm	$75.00
D7911	Complicated suture – up to 5 cm	$85.00
D7912	Complicated suture – greater than 5 cm	$95.00
D7920	Skin graft (identify defect covered, location and type of graft)	$310.00
D7921	Collection and application of autologous blood concentrate product	Not A Benefit
D7940	Osteoplasty – for orthognathic deformities	$1,300.00
D7941	Osteotomy – mandibular rami	$2,000.00
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$2,800.00
D7944	Osteotomy – segmented or subapical	$600.00
D7945	Osteotomy – body of mandible	$600.00
D7946	LeFort I (maxilla – total)	$1,300.00
D7947	LeFort I (maxilla – segmented)	$2,000.00
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$2,300.00
D7949	LeFort II or LeFort III – with bone graft	$3,000.00
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$800.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$1,000.00
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$750.00
D7953	Bone replacement graft for ridge preservation - per site	Not A Benefit
D7955	Repair of maxillofacial soft and/or hard tissue defect	By Report
D7960	Frenulectomy also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$200.00
D7963	Frenuloplasty	$200.00
D7970	Excision of hyperplastic tissue – per arch	$100.00
D7971	Excision of pericoronal gingiva	$50.00
D7972	Surgical reduction of fibrous tuberosity	$50.00
D7980	Sialolithotomy	$235.00
D7981	Excision of salivary gland, by report	$521.00
D7982	Sialodochoplasty	$365.00
D7983	Closure of salivary fistula	$120.00
D7990	Emergency tracheotomy	$200.00
D7991	Coronoidectomy	$558.00
D7995	Synthetic graft – mandible or facial bones, by report	$335.00
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report	Not A Benefit
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$45.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Not A Benefit
D7999	Unspecified oral surgery procedure, by report	By Report
Orthodontics		
D8010	Limited orthodontic treatment of the primary dentition	Not A Benefit
D8020	Limited orthodontic treatment of the transitional dentition	Not A Benefit
D8030	Limited orthodontic treatment of the adolescent dentition	Not A Benefit
D8040	Limited orthodontic treatment of the adult dentition	Not A Benefit
D8050	Interceptive orthodontic treatment of the primary dentition	Not A Benefit
D8060	Interceptive orthodontic treatment of the transitional dentition	Not A Benefit
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not A Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$750.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate - primary dentition	$425.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate - mixed dentition	$625.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate - permanent dentition	$925.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management - primary dentition	$425.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management - mixed dentition	$625.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management - permanent dentition	$1,000.00
D8090	Comprehensive orthodontic treatment of the adult dentition	Not A Benefit
D8210	Removable appliance therapy	$245.00
D8220	Fixed appliance therapy	$245.00
D8660	Pre-orthodontic treatment visit	$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion	$210.00
D8670	Periodic orthodontic treatment visit (as part of contract) cleft palate - primary dentition	$125.00
D8670	Periodic orthodontic treatment visit (as part of contract) cleft palate - mixed dentition	$140.00
D8670	Periodic orthodontic treatment visit (as part of contract) cleft palate - permanent dentition	$300.00
D8670	Periodic orthodontic treatment visit (as part of contract) facial growth management - primary dentition	$125.00
D8670	Periodic orthodontic treatment visit (as part of contract) facial growth management - mixed dentition	$140.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D8670	Periodic orthodontic treatment visit (as part of contract) facial growth management - permanent dentition	$300.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$244.00
D8690	Orthodontic treatment (alternative billing to a contract fee)	Not A Benefit
D8691	Repair of orthodontic appliance	$50.00
D8692	Replacement of lost or broken retainer	$200.00
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	$30.00
D8999	Unspecified orthodontic procedure, by report	By Report
Adjunctives		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$45.00
D9120	Fixed partial denture sectioning	$50.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$45.00
D9211	Regional block anesthesia	Global
D9212	Trigeminal division block anesthesia	Global
D9215	Local anesthesia in conjunction with operative or surgical procedures	Global
D9220	Deep sedation/general anesthesia – first 30 minutes	$91.35
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$14.01
D9230	Inhalation of nitrous oxide/anxiolysis analgesia	$25.00
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$42.14
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$21.07
D9248	Non-intravenous conscious sedation	$25.00
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	Global
D9410	House/Extended care facility call	$20.00
D9420	Hospital or ambulatory surgical center call	$50.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20.00
D9440	Office visit – after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	Not A Benefit
D9610	Therapeutic parenteral drug, single administration	$15.00
D9612	Therapeutic parenteral drug, two or more administrations, different medications	Global
D9630	Other drugs and/or medicaments, by report	Not A Benefit
D9910	Application of desensitizing medicament	$43.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not A Benefit
D9920	Behavior management, by report	Not A Benefit
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	$15.00

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D9940	Occlusal guard, by report	Not A Benefit
D9941	Fabrication of athletic mouth guard	Not A Benefit
D9942	Repair and/or reline of occlusal guard	Not a Benefit
D9950	Occlusion analysis – mounted case	$180.00
D9951	Occlusal adjustment – limited	$25.00
D9952	Occlusal adjustment – complete	$400.00
D9970	Enamel microabrasion	Not A Benefit
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	Not A Benefit
D9972	External bleaching - per arch - performed in office	Not A Benefit
D9973	External bleaching – per tooth	Not A Benefit
D9974	Internal bleaching – per tooth	Not A Benefit
D9975	External bleaching for home application, per arch: includes materials and fabrication of custom trays	Not A Benefit
D9999	Unspecified adjunctive procedure, by report	By Report

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Section 6 - Forms

Denti-Cal Forms

Only Denti-Cal specific, State-approved forms, are accepted by Denti-Cal. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Denti-Cal covered services. No duplicates or photocopies will be accepted or processed. Signatures in blue or black ink are required: rubber signature stamps will not be accepted.

Treatment Authorization Request (TAR)/ Claim Forms

- DC-202 – Preimprinted, No Carbon Required (NCR)
- DC-209 – NCR for continuous pin-fed printers
- DC-217 – Single sheet for laser printers

Claim Inquiry Forms (CIFs)

- DC-003

Envelopes for TAR/Claim Forms/ Correspondence

- DC-006C – for submitting radiographs/attachments for Electronic Data Interchange (EDI) TAR/Claims forms
- DC-007 - correspondence
- DC-206 – for submitting TAR/Claim forms that are not EDI

Envelopes for Submitting Radiographs

- DC-014E – large envelopes for submitting radiographs with EDI
- DC-014F – small envelopes for submitting radiographs with EDI
- DC-214A – large envelopes for submitting radiographs with TAR/Claim forms
- DC-214B – small envelopes for submitting radiographs with TAR/Claim forms

EDI Labels

- DC-018A - 12-up sheet of labels
- DC-018B - 1-up continuous labels
- DC-018C - 3-up continuous labels

Ordering Forms

When ordering forms, be sure to request an adequate supply of TAR/Claim forms, CIFs, and Justification of Need for Prosthesis forms, plus X-ray and mailing envelopes. The Forms Reorder Request (DC-204) is to be used to order forms from the Denti-Cal's forms supplier.

The forms vendor will verify that the National Provider Identifier (NPI) number submitted for preimprinting matches what is on record at Denti-Cal. Once confirmed, the inventory will be preimprinted with the NPI. However, if the information found on the Forms Reorder Request does not match what the forms vendor has received from Denti-Cal, the order will not be filled.

The Forms Reorder Request form (DC-204) should be mailed or faxed to the warehouse vendor:

Denti-Cal Forms Reorder
11155 International Drive, MS C25
Rancho Cordova, CA 95670
Fax: (877) 401-7534

Do not phone the warehouse: they are not staffed to handle telephone requests.

Upon receiving Denti-Cal forms and envelopes, verify that any pre-printed information such as address and/or NPI number is correct. If there are errors, then please call the Denti-Cal toll free at (800) 423-0507.

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Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR)

OCR/ICR technology allows for a more automated process of capturing information from paper documents and enables Denti-Cal to electronically adjudicate paper forms. Denti-Cal's goal is to decrease processing time, improve responsiveness to provider and beneficiary (patient) inquiries, and increase adjudication accuracy.

To ensure optimum results and avoid denials, please follow the specifications listed below.

Do:

- Use only Denti-Cal provided forms
- On TAR/Claim forms, leave boxes 11 through 18 blank, unless indicating "yes." OCR reads any mark in boxes 11 through 18 as a "yes", even if the answer is "no."
- Use a laser printer for best results. If handwritten documents must be submitted, use neat block letters, blue or black ink, and stay within field boundaries.
- Use a 10 point, plain font (such as Arial), and use all capital letters
- Use a 6-digit date format without dashes or slashes, e.g., mmddyy (123116)
- Use only Denti-Cal TAR/Claim forms
- Print within the lines of the appropriate field
- Submit notes and attachments on 8 ½" by 11" paper. Small attachments must be taped to standard paper in order to go through the scanner.
- Submit notes and attachments on one side of the paper only. Double-sided attachments require copying and additional preparation for the scanners which will cause delays in adjudication.
- Enter quantity information in the quantity field. OCR does not read the description of service field to pick up the quantity.
- On TAR/Claim forms, complete boxes 19 and 20. Enter the complete Billing Provider Name and NPI to ensure appropriate payment to the correct billing number.
- Remember that the following TAR/Claim forms are no longer available and should not be used: DC-002A, DC-002B, DC-009A, DC-009B, DC-017A, and DC-017B
- Always apply a handwritten signature in blue or black ink

Do Not:

- Use correction fluid or tape
- Use a dot matrix/impact printer
- Use italics or script fonts
- Mix fonts on the same form
- Use fonts smaller than 10 point
- Use arrows or quote/ditto marks to indicate duplicate dates of service, National Provider Identifier (NPI), etc.
- Use dashes or slashes in date fields
- Print slashed zeros
- Use photocopies of any Denti-Cal forms
- Use highlighters to highlight field information (this causes field data to turn black and become unreadable)
- Submit two-sided attachments
- Enter quantity information in the description of service field
- Put notes on the top or bottom of forms
- Fold any forms
- Use labels, stickers, or stamps on any Denti-Cal forms
- Use rubber signature or "signature on file" stamps
- Place additional forms, attachments, or documentation inside the X-ray envelope. This will cause a delay in adjudication and processing.

Correct Use of Denti-Cal Envelopes

Denti-Cal continues to receive X-ray envelopes that are incorrectly addressed or prepared, have no address, or are empty. Some providers also submit radiographs without using the correct preimprinted or typed X-ray envelopes specifically designed for that purpose. Radiographs and photographs will not be returned.

- When submitting claims for multiple patients in one envelope, ensure that the radiographs/photographs for the respective patient are stapled to the associated claim/TAR. Use only one staple in upper right or left corner of the claim/TAR to attach radiographs or paper copies.
- Do not print two separate documents on one piece of paper (e.g., an EDI Notice of Authorization for one beneficiary on one side, and another EDI Notice of Authorization for a different beneficiary on the other side).
- Enclose mounted, dated, and well-marked radiographs and photographs in the appropriate X-ray envelope. Include the dentist's name, Denti-Cal provider number, and beneficiary name and Medi-Cal ID number on the X-Ray mount. Duplicate radiographs, paper radiographs, and photographs should also be marked clearly so they are identifiable for processing. The date on all radiographs, paper copies, and photographs must be in month/date/year format.
- Plastic sleeve mounts should be clean and have the label containing the required information placed on the front side of the mount.
- If the provider has a device such as a scanner that can transfer radiographs onto paper, Denti-Cal will accept the paper copy instead of the regular film. Paper copies of radiographs must be of good quality to be accepted and must be larger than 2 inches by 3.5 inches (about the size of a business card). If the resolution of the paper image is inadequate, Denti-Cal will request the original film, which can delay processing. Be sure to indicate on the paper copy the date the radiograph was taken and which side of the mouth. Paper copies of radiographs will not be returned.
- Paper copies should be printed on 20lb or heavier paper, but do not use glossy or photo paper.
- Do not fold radiographs or photographs.
- Only use X-ray envelopes for radiographs or paper radiographs. All other attachments and documentation should be stapled to the TAR/Claim form to reduce processing delays. Do not overfill X-ray envelopes. The appropriately-sized envelopes should be used for all radiographs submitted to prevent damaged envelopes and/or lost radiographs.
- Up to three unmounted radiographs may be submitted by placing them in unsealed coin-size envelopes and inserting the coin-size envelopes into the X-ray envelopes provided by Denti-Cal. The coin-sized envelope should be labeled with the provider name, NPI, beneficiary name, and date.

Denti-Cal offers the following special envelopes to be used by the dental office for enclosing radiographs/photographs with claim and TAR forms:

- DC-014E – Large envelopes for submitting radiographs/photographs with EDI documents
- DC-014F – Small envelope for submitting radiographs/photographs with EDI documents
- DC-214A – Large envelopes for submitting radiographs/photographs with these TAR/Claims: DC-20w2, DC-209, DC-217
- DC-214B – Small envelopes for submitting radiographs/photographs with these TAR/Claims: DC-202, DC-209, DC-217

Radiographs should be placed in these envelopes. Loose radiographs can become separated and lost, which can delay the time it takes Denti-Cal to process documents.

Denti-Cal also provides the following envelopes for mailing TAR/Claim forms:

- **DC-006C** – Large envelope with red border for mailing EDI documents, which should only contain:
  - Attachments and back-up documentation to support authorized treatment
  - X-ray envelopes DC-014E and DC-014F (these are not preimprinted; please order accompanying DC-018A, B, or C mailing labels)
- **DC-206** – Large envelope for mailing TAR/Claim forms, which should only contain:
  - TAR/Claim forms
  - Claim Inquiry Forms (CIFs)
  - Resubmission Turnaround Documents (RTDs) relating to TAR/Claim forms
  - NOAs submitted for payment or reevaluation
  - EDI NOAs printed onto paper for payment and/or EDI RTDs printed onto paper related to claims (do not attach EDI label)
  - EDI RTDs printed onto paper related to TARs (do not attach EDI label)
  - Preimprinted X-ray envelopes (DC-214A and DC-214B)

Treatment Authorization Request (TAR)/Claim Forms

The TAR/Claim form is used to request authorization of proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Denti-Cal. An incomplete or inaccurate TAR or Claim will delay processing and may result in the generation of a RTD or denial.

Denti-Cal-specific forms are the only forms processed under the Denti-Cal Program, whether for authorization of covered services or payment of rendered treatment.

The format of the following forms is identical.

- DC-202 (No Carbon Required (NCR) TAR/Claim forms)
- DC-209 (continuous TAR/Claim forms)
  Page 1 – Submit first sheet to Denti-Cal
  Page 2 – Retain second sheet
- DC-217 (single-sheet TAR/Claim forms for use in laser printers)

For scanning purposes, the forms are produced with red ink, and providers are requested to use only blue or black ink on any forms submitted to Denti-Cal.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.

Sample TAR/Claim Form Submitted as a Treatment Authorization Request (TAR)

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	3. SEX (M / F)	4. PATIENT BIRTHDATE (MO / DAY / YR)	5. MEDI-CAL BENEFITS ID CARD NUMBER
BENEFICIARY, JANE	X	07 / 04 / 55	9999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
5498 PRIMROSE WAY	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
ANYTOWN, CA	90100	

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
			YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. BILLING PROVIDER NPI
ADAMS, JAMES	1234567891

21. MAILING ADDRESS	TELEPHONE NUMBER
3157 MAIN ST, STE 320	(888) 555-0188

CITY, STATE	ZIP CODE
ANYTOWN, CA	90100

BIC Issue Date: _____

EVC #: _____

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH #, LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
U		1 PARTIAL DENTURE - RESIN BASE			D5211	400.00	
L		2 PARTIAL DENTURE - RESIN BASE			D5212	400.00	
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	800.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	10242016

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X Jim Adams — SIGNATURE

10/27/16 — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

www.denti-cal.ca.gov

DC-217 (R 9/13)

SAMPLE

Sample TAR/Claim Form Submitted as a Claim

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.) BENEFICIARY, JANE	3. SEX M / F: X	4. PATIENT BIRTHDATE MO 07 DAY 04 YR 55	5. MEDI-CAL BENEFITS ID CARD NUMBER 9999999999
6. PATIENT ADDRESS 5498 PRIMROSE WAY			7. PATIENT DENTAL RECORD NUMBER
CITY, STATE ANYTOWN, CA		ZIP CODE 90100	8. REFERRING PROVIDER NPI

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
			YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.) ADAMS, JAMES	20. BILLING PROVIDER NPI 1234567891
21. MAILING ADDRESS 3157 MAIN ST, STE 320	TELEPHONE NUMBER (888) 555-0188
CITY, STATE ANYTOWN, CA	ZIP CODE 90100

BIC Issue Date: 01/15/06

EVC #: 123456789A1

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH # LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Exam	111416		D0150	25.00	9912345678
		2 4 BW X-Rays	111416		D0274	20.00	9912345678
		3 Additional PAs	111416	6	D0230	24.00	9912345678
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	69.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	11142016

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X Jim Adams — SIGNATURE

11/14/16 — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

www.denti-cal.ca.gov

DC-217 (R 9/13)

SAMPLE

How to Complete the TAR/Claim Form

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed.

Denti-Cal's evaluation of TARs and Claims will be more accurate when narrative documentation is included. The following reminders and tips help office staff prepare narrative documentation for some common Denti-Cal procedures:

- "Comments" area (Field 34) of the
- TAR/Claim form is used when written narrative documentation is required. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
- Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form (Field 34).
- If submitting electronically, abbreviate comments to make optimum use of allotted space.

Fill in each field as follows:

1. PATIENT NAME: Enter the beneficiary's last name, first name and middle initial.
2. Field removed.
3. **PATIENT SEX**: Check "M" for male or "F" for female.
4. **PATIENT BIRTHDATE**: Enter the beneficiary's birthdate (mmddyy). The birthdate is used to help identify the beneficiary. Differences between the birthdate on the Medi-Cal Identification Card and the birthdate given by the beneficiary should be brought to the attention of the beneficiary for correction by his/her County Social Services office.
5. **MEDI-CAL BENEFITS ID CARD NUMBER**: Enter the beneficiary's 14-digit number as it appears on the Medi-Cal identification card. Completion of this field is required.
6. **PATIENT ADDRESS**: Enter the beneficiary's current address. If the beneficiary resides in a convalescent home or other health care facility, indicate the full name, complete address and phone number, including area code, of the convalescent home or other health care facility. Please Note: It is important to accurately document the beneficiary's name, birthdate, Medi-Cal Benefits ID Card number and current address when submitting billing forms to Denti-Cal. Denti-Cal may need to contact the beneficiary for screening, and if the beneficiary's information is incorrect, it can cause delays in processing the document.
7. **PATIENT DENTAL RECORD NUMBER**: If the provider assigns a Dental Record Number or account number to a beneficiary, enter the assigned number here. The number will then appear on all related correspondence from Denti-Cal.
8. **REFERRING PROVIDER NUMBER**: Enter the license number of the dentist who referred the beneficiary, if applicable.
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the beneficiary's name, the BIC or CIN, the date that the radiograph was taken, and the provider's name and provider number.
10. **OTHER ATTACHMENTS**: Check "yes" if additional documents are attached to the TAR/Claim form. Examples of other attachments include related correspondence, periodontal charts, operating room reports or physician's report describing the beneficiary's specific medical condition. Do not place attachments inside the X-ray envelope.
11. **ACCIDENT/INJURY?** EMPLOYMENT RELATED? Check "yes" if the beneficiary was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the beneficiary's accident or injury was caused by or occurred at work, check "yes." Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."

12. **ELIGIBILITY PENDING?** (FOR TAR ONLY) Check "yes" if the beneficiary has applied for Medi-Cal eligibility which has not yet been approved and a TAR has been submitted for that beneficiary. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private- or employer-paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the TAR/Claim form to Denti-Cal. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits, fee schedule, or denial letter. For more information on other coverage, see "Section 9: Special Programs" of this Handbook. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
14. **MEDICARE DENTAL COVERAGE?** Check "yes" if the service performed is covered by Medicare. Medicare must be billed prior to submitting any Medicare-covered service to Denti-Cal. Attach a copy of the Explanation of Medicare Benefits form or denial letter. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
15. **RETROACTIVE ELIGIBILITY?** Check "yes" if the services have been performed and the provider is requesting payment for the reason described in the "COMMENTS" section, Field 34. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
16. **CHDP (CHILD HEALTH AND DISABILITY PREVENTION)?** Check "yes" if the treatment is related to a previous CHDP screening. The CHDP Children's Treatment Program (CTP) claims must be submitted with a current PM 160 (health assessment screening form) attached to the Denti-Cal TAR/Claim form. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
17. **CCS (CALIFORNIA CHILDREN'S SERVICES)?** Check "yes" if any services performed are authorized by CCS. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
18. **MF-O (MAXILLOFACIAL-ORTHODONTIC) SERVICES?** Check "yes" if the claim is for maxillofacial-orthodontic services. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
19. **BILLING PROVIDER NAME**: Enter the billing provider's name in either the "doing business as" format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
20. **BILLING PROVIDER NUMBER**: Enter the billing Provider Number (NPI). NOTE: The Provider Number and correct service office (where the services were administered) must be present and correct on all forms. Also, the NPI must be registered with Denti-Cal prior to submitting claims.
21. **BILLING PROVIDER ADDRESS AND TELEPHONE NUMBER**: Enter the service office address where treatment is rendered. A service office address should be a street address, including city, state and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.
    If the service office address is different from the address where payment is received, please notify Denti-Cal so payment can be directed to the appropriate location.
    It is important to include the telephone number of the service office, including area code, so Denti-Cal can contact the provider if questions arise while processing documents.

Please Note: It is important that the billing provider's name, Medi-Cal provider number (NPI), address and telephone number are accurate and match the information Denti-Cal has recorded on its system. TAR/Claim forms pre-printed with the provider's name/number/address are available at no charge from the Denti-Cal forms supplier. Please check this information for accuracy on all pre-printed supplies. If forms printed from your office computer are being used, please ensure the computer is programmed with the correct provider information.

22. **PLACE OF SERVICE**: Check the appropriate box indicating where service was performed (claim) or will be performed (TAR), i.e., Office, Home, Clinic/Dental School Clinic, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), Hospital In-Patient, Hospital Out-Patient or Other (specify place of service). Those providers treating a SNF or ICF beneficiary outside the facility in which they reside, must use POS 4 or 5 (only) and must indicate the actual place of service in Box 34.
    BIC ISSUE DATE/EVC# AREA: This area is only used to record the new issue date for Benefits Identification Cards (BICs).
23. Field removed
24. Field removed
25. Field removed.
26. **TOOTH NO./LTR, ARCH, QUAD**: Use universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use arch code "U" (upper), "L" (lower). Use quadrant code "UR" (upper right), "UL" (upper left), "LR" (lower right), and "LL" (lower left). For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
27. **TOOTH SURFACES**: Use "M" (mesial), "D" (distal), "O" (occlusal), "I" (incisal), "L" (lingual or palatal), "B" (buccal), and "F" (facial).
28. **DESCRIPTION OF SERVICE**: Furnish a brief description for each service. Standard abbreviations are acceptable.
29. **DATE SERVICE PERFORMED**: For TARs, this field is blank. For payment claims only. Indicate the date the service was performed, using the six (6) numerical digits e.g., mmddyy.
30. **QUANTITY:** For the procedures having multiple occurrences, indicate the number of occurrences of the procedure.
31. **PROCEDURE NUMBERS**: Use only the Current Dental Terminology version 13 (CDT-13) procedure codes.
32. **FEE**: Enter the usual customary and reasonable (UCR) fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.
33. **RENDERING PROVIDER NO**.: A rendering provider (NPI) number is required in Field 33 on all claim forms and NOAs for any procedure codes other than the following: D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0322, D0330, D0340, D0350, D0502, D1110, D1120, D1206, D1208, and D1351. If a rendering provider number (NPI) is not indicated on the TAR/Claim form (for all procedure codes other than those listed above), the TAR/Claim form will be delayed and a RTD will be issued to request the missing information. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service**. The NPI should be entered on the claim line for each service performed.
34. **COMMENTS**: Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. Narrative documentation should always state facts as they pertain to the case. Printed or typewritten documentation is preferred. It is helpful to note in this area that narrative documentation is attached when including narrative documentation on a separate piece of paper.
    When preparing a TAR for a beneficiary with an authorized representative who is not identified on the Medi-Cal card, please include the representative's name and address in this area on the TAR form. This will assist Denti-Cal in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information. This area should also be used to indicate the:
    - submitter ID of the billing intermediary, if applicable

- eligibility confirmation number given by the AEVS when verifying eligibility
- name, address and telephone number of the Skilled Nursing Facility or Intermediate Care Facility.

35. **TOTAL FEE CHARGED**: The sum of the fees entered in field 32 for all lines.
36. **PATIENT SHARE-OF-COST AMOUNT: FOR PAYMENT CLAIMS ONLY**. The dollar amount of the beneficiary's share-of-cost collected by or due from a recipient who has a share-of-cost obligation. If there is no share of cost, then leave this field blank.
37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY**. The dollar amount of "other coverage" payments the provider has received for the listed procedures. If either Field 13 (OTHER DENTAL COVERAGE) or Field 14 (MEDI-CARE DENTAL COVERAGE) is checked "yes", the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial from the private dental insurance carrier or Medicare must be attached to the TAR/Claim form for payment.
38. **DATE BILLED**: Enter the date the form is mailed using six (6) numerical digits, e.g., mmddyy.
39. **SIGNATURE BLOCK**: The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting prior authorization or payment. An original signature in blue or black ink is also required (stamped signatures will not be accepted).

After providing all necessary information on the form please follow these steps:

1. Detach the "Dentist Copy" (page 2, where applicable) and retain for office records.
2. Check page 1 for completeness and legibility.
3. Place attachments, if any, behind the form or the X-ray envelope. Staple them to the back of the form, in the upper right corner. Only staple the attachments once to the form. Excessive staples will delay processing.
4. Mail completed TAR/Claim forms in the large mailing envelopes. Up to 10 forms can be mailed in a single envelope.

   Mail completed TAR/Claim forms to:

   Denti-Cal
   PO Box 15610
   Sacramento, CA 95852-0610

   TAR/Claim forms used for authorization (as a Treatment Authorization Request) should be mailed separately from TAR/Claim forms requesting payment for services rendered.
5. If submitting two TAR/Claim forms for the same beneficiary, staple them together in the upper right corner.

How to Submit a Claim for a Beneficiary with Other Coverage

A beneficiary having other coverage does not change the prior authorization requirements under Denti-Cal. Denti-Cal will process the prior authorization, and a Notice of Authorization will indicate the amount Denti-Cal would pay as if there were no other coverage.

When completing the claim for payment or NOA, be sure to include the following:

Field 10. ATTACHMENTS:

Include a copy of other coverage carrier's Explanation of Benefits/Readmittance Advice (EOB/RA) or Proof of Denial letter or fee schedule.

Field 13. OTHER DENTAL COVERAGE?

Check "yes," indicating beneficiary has other dental insurance coverage.

Field 34. COMMENTS:

Provide full name and address of other coverage carrier and name, member's ID for that particular carrier, and group number of the policyholder.

Field 37. OTHER COVERAGE AMOUNT:

Fill in amount paid by other coverage carrier.

How to Submit a TAR for Orthodontic Services

Providers must include a complete orthodontic treatment plan containing:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Periodic Orthodontic Treatment Visits (D8670)
- Orthodontic Retention (D8680)

The treatment plan may include:

- Radiographs (Procedure D0210)
- Panoramic radiographic image (Procedure D0330)
- Cephalometric head radiographic image and tracings (Procedure D0340)

Include the quantity, number of visits for active treatment (Procedure D8670). The quantity can vary depending on the type of case and the phase of dentition. Also, indicate the "case type" (e.g. cleft palate or craniofacial anomaly) and "Phase of dentition" (primary, mixed or permanent) in Field 34 (COMMENTS).

Note: Craniofacial anomalies cases may request Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6) and must also submit a separate authorization for these services prior to requesting a complete orthodontic treatment plan.

Reminders:

- Attach HLD Score Sheet (DC-016) to TAR
- Properly pack and box diagnostic casts
- Send diagnostic casts separately, approximately five days prior to sending the TAR

A Denti-Cal orthodontic consultant will determine if the case qualifies for treatment under the Denti-Cal guidelines for orthodontic services.

Please refer to "Section 9: Special Programs" for more information on orthodontic services.

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Notice of Authorization (NOA) (DC-301, Rev. 10/06)

The NOA, a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization, is printed with the same information as originally submitted. Presently the NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

Providers may request a reevaluation for denied and/or additional procedures requested in certain instances. Changes to the billed amount or procedures not requiring prior authorization will not be considered.

Reevaluations may be considered when:

- another procedure requiring prior authorization has been requested.
- there is a reversal of denied procedures, e.g., missing radiographs have been submitted.
- there is a complex treatment plan.

Denti-Cal has created the following NOA message when a reevaluation has been requested:

> The submitted changes have been reviewed. Original authorization period still valid.

Denti-Cal has revised the following NOA message when a reevaluation has been re-quested:

> Resubmission not processed. No additional information received. Original authorization period still valid.

To expedite processing and prevent delays or possible denial, please remember to check the box found in the upper right corner of the NOA. Only one reevaluation may be requested per NOA and it must be received prior to the expiration date.

Prior to completing the form, verify that the information printed on the form is correct.

The NOA is printed by Denti-Cal with the following information:

1. Authorized period of time (180 days).
2. Beneficiary information (except Medi-Cal ID Number).
3. Provider information
4. Procedures allowed, modified, disallowed
5. Allowances
6. Adjudication Reason Codes

Denti-Cal will indicate on the NOA if the services requested are allowed, modified or disallowed. For those allowed services, fill in the appropriate shaded areas on the top portion of the NOA form, including the dates for all services. Submit the completed and signed form for payment for the services performed. Also, fill in the appropriate shaded areas on a copy and retain this one for office records.

The NOA has a statement printed on the bottom of the form that reads: “NOTE: Authorization does not guarantee payment. Payment subject to beneficiary's eligibility.” This statement has been added to remind the dentist to verify the beneficiary's eligibility prior to providing services.

Time limitations for billing services provided under the Denti-Cal Program are as follows:

- six calendar months after the end of the month in which the service is authorized will be considered for full payment (100 percent of the SMA).
- seven to nine months after the end of the month in which the service is authorized will be considered for payment at 75 percent of the SMA amount.
- ten to twelve months after the end of the month in which the service is authorized will be considered for payment at 50 percent of the SMA amount.

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, please send the expired NOA back to Denti-Cal so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

Note: If a beneficiary's 21st birthday occurs during the authorized period of time, most services may be completed with the exception of orthodontic treatment. (See Section 5 - Manual of Criteria).

Sample Notice of Authorization (NOA)

STAPLE HERE

DO NOT WRITE IN THIS AREA

STAPLE HERE

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

0331810024

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 011009
TO: 051309

RE-EVALUATION IS REQUESTED ☐ YES

PAGE 1 OF 1

1. BENEFICIARY NAME (LAST, FIRST, M.I.)	3. SEX (M / F)	4. BENEFICIARY BIRTHDATE (MO. / DAY / YR)	5. BENEFICIARY MEDI-CAL I.D. NO.
Last Name, First Name	X	mm / dd / yyyy	

9. RADIOGRAPHS ATTACHED? (CHECK IF YES) HOW MANY?	10. OTHER ATTACHMENTS? (CHECK IF YES)	11. ACCIDENT / INJURY? (CHECK IF YES) EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE? (CHECK IF YES)	16. CHDP	7. BENEFICIARY DENTAL RECORD NO.

Adams, James DDS XXXXXXXXX
30 Main Street XXX-XXX-XXX
Anytown, CA XXXXX-XXXX

23. BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER ARCH	27. SURFACES	28.	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
		19	1	Crown Cast Base Metal		01	D2791	410.00	340.00		XXXXXXXXXX
		20	2	Crown Cast Base Metal		01	D2791	410.00	340.00		XXXXXXXXXX
			3								
			4								
			5								
			6								
			7								
			8								
			9								
			10								
			11								
			12								
			13								
			14								
			15								
			16								
			17								
			18								
			19								
			20								
			21								
			22								

Sample

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- ADJUDICATION REASON CODES - SEE PROVIDER MANUAL
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO BENEFICIARY ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

34. COMMENTS

35. TOTAL FEE CHARGED	820.00
46. TOTAL ALLOWANCE	680.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

NOTICE OF AUTHORIZATION
- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. **TREATMENT COMPLETED - PAYMENT REQUESTED**
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ ORIGINAL SIGNATURE REQUIRED _____ DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SIGN ONE COPY AND SEND IT TO DENTI-CAL - RETAIN THE OTHER FOR YOUR RECORDS.

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

How to Complete the NOA

The shaded fields on the NOA require completion by the dental office. All fields listed below are required unless otherwise stated.

1. **BENEFICIARY NAME (LAST, FIRST, MI)**: Pre imprinted by Denti-Cal.
2. Field removed.
3. **SEX**: Preimprinted by Denti-Cal.
4. **BENEFICIARY BIRTHDATE**: Preimprinted by Denti-Cal.
5. **BENEFICIARY MEDI-CAL IDENTIFICATION NUMBER**: Enter the beneficiary's 14-digit State Recipient Identifier as it appears on the Medi-Cal identification card (Benefits Identification Card, "BIC"). Completion of this field is required.
6. Field removed.
7. **BENEFICIARY DENTAL RECORD NO**.: Enter the dental record for the beneficiary. This field is optional.
8. Field removed.
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the beneficiary's name and BIC, the date the radiograph was taken, and the provider's name and provider number.
10. **OTHER ATTACHMENTS?** Check "yes" if additional documents are attached to include related correspondence, periodontal charts, operating room reports, or physician's report describing the beneficiary's specific medical condition. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
11. **ACCIDENT/INJURY?** EMPLOYMENT RELATED? Check "yes" if the beneficiary was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the beneficiary's accident or injury was "Employment Related" check "yes." Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
12. Field removed.
13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private or employer paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the NOA form to Denti-Cal. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, BIC, and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits, fee schedule or denial letter. See "Section 2: Program Overview" of this Handbook for additional information on other coverage. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
14. Field removed.
15. Field removed.
16. **CHDP -CHILD HEALTH AND DISABILITY PREVENTION?** Check "yes" if the treatment is related to a previous CHDP screening. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
17. Field removed.
18. Field removed.
19. Field removed.
20. Field removed.
21. Field removed.
22. Field removed.
23. **BIC ISSUE DATE. EVC #:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).
24. Field removed.
25. Field removed.
26. **TOOTH NO. OR LETTER ARCH**: The tooth number or letter arch here. For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
27. **SURFACES**: Pre imprinted by Denti-Cal. The surface of the tooth being restored as indicated by tooth surface (F=facial, B=buccal, O=occulsal, M=mesial, D=distal, L=lingual).
28. **DESCRIPTION OF SERVICES**: Preimprinted by Denti-Cal. The type of service the provider is

authorized to perform (X-rays, teeth cleaning, fillings, etc.).

29. DATE SERVICE PERFORMED: Indicate the date the service was performed. Use six (6) numerical digits, e.g., mmddyy.
30. **QUANTITY**: Preimprinted by Denti-Cal. The quantity of the service provided.
31. **PROCEDURE NUMBER**: Preimprinted by Denti-Cal. Enter the CDT-13 procedure code for the service.
32. **FEE**: Preimprinted by Denti-Cal. The fee charged for each rendered service.
33. **RENDERING PROVIDER NO.:** A rendering provider (NPI) number is required in Field n all TAR/Claim forms and NOAs for any procedure codes other than the following: D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0322, D0330, D0340, D0350, D0502, D1110, D1120, D1206, D1208, and D1351. If a rendering provider number (NPI) is not indicated on the NOA (for all procedure codes other than those listed bove), the NOA will be delayed. A RTD will be issued requesting the missing data. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service**. The NPI should be entered on the claim line for each service performed.
34. **COMMENTS**: Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. It is helpful to note in this area if additional documentation is attached.
35. **TOTAL FEE CHARGED**: Preimprinted by Denti-Cal. The total dollar amount requested by the provider office on the original TAR.
36. **BENEFICIARY SHARE-OF-COST AMOUNT**: The dollar amount of the beneficiary's share of cost collected by or due from a recipient who has a share-of-cost obligation. If there is no share of cost, then leave this field blank.
37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of “other coverage” payments the provider has received for the listed procedure. If Field 13 (OTHER DENTAL COVERAGE) is checked “yes,” the amount received from the private dental insurance carrier must be entered. The Explanation of Benefits (EOB) or denial letter from the private dental insurance carrier must be attached to the NOA form for payment.
38. **DATE BILLED**: Enter the date the form is mailed using six (6) numerical digits, e.g., mmddyy.
39. **SIGNATURE BLOCK**: The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting payment. The signature must be an original signature in blue or black ink. Rubber stamp signatures are not acceptable.

    Additional services not requiring prior authorization may be added to the NOA when submitted for payment. However, radiographs or documentation must be sent with the NOA to justify the additional services. After providing all necessary information on the form, please follow these steps:

    - Sign and date one copy of the NOA. Mail this one to Denti-Cal. Multi-page NOAs should be returned together.
    - Retain the other copy for office records.
    - If radiographs are being submitted, enclose them in the green-bordered X-ray envelope and attach it to the NOA.
    - Mail completed forms in the large green-bordered envelopes that have been provided. Up to 10 forms can be mailed in a single envelope.

    Mail NOAs to the post office box listed below:

    Denti-Cal
    Attn: Correspondence
    PO Box 15610
    Sacramento, CA 95852-0609

40. Field removed.
41. **DELETE**: If treatment was not performed, place an “X” in the column corresponding to the treatment not performed. Do NOT strike out the entire line.
42. **ALLOWANCE**: Pre imprinted by Denti-Cal. Reflects the dollar amount Denti-Cal will pay for each procedure.

43. **ADJ. REASON CODE**: Pre imprinted by Denti-Cal. Indicates the adjudication reason code (if applicable).
44. **DATE PROSTHESIS ORDERED**: If an approved prosthesis cannot be delivered, indicate the date the prosthesis was ordered from the dental laboratory.
45. **PROSTHESIS LINE FIELD**: Indicate the number of the line corresponding to procedure billed for the undelivered prosthesis.
46. **TOTAL ALLOWANCE**: Pre imprinted by Denti-Cal. Reflects the dollar amount Denti-Cal will pay for the entire NOA.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.

Reevaluation of the Notice of Authorization (NOA) For Orthodontic Services

Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Denti-cal on or before the expiration date (within 180 days).

There are no reevaluations on "exploded" NOAs. An explanation of the term "exploded" is: the submitted Treatment Authorization Request (TAR) will include all requested orthodontic treatments but when Denti-Cal sends the NOAs, the NOAs will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Remaining Treatment Visit NOAs (Procedure D8670) will be sent one per quarter over the course of the treatment
- Orthodontic Retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment

Providers are reminded:

- A reevaluation may only be requested on a denied NOA for the Orthodontic Treatment Plan only
- Check the "Reevaluation Box" on the NOA
- Denti-Cal must receive the NOA prior to the expiration date
- Attach HLD and all additional documentation to NOA
- Do not sign the NOA
- NOA may only be submitted for reevaluation one (1) time
- See "Section 9: Special Programs" of this Handbook for more information on Orthodontic services.

Reevaluations

Only one request for reevaluation per NOA is allowed, and it must be received prior to the expiration date.

To request reevaluation of a NOA, follow these steps:

1. Check the box marked “REEVALUATION IS REQUESTED” at the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include additional documentation and/or enclose radiographs as necessary.
4. Return to:

   Denti-Cal
   PO Box 15609
   Sacramento, CA 95852-0609

5. After the reevaluation is made, a new NOA will be generated and sent to your office.

If a denial is upheld and another review is wanted, a new TAR must be submitted.

Outstanding Treatment Authorization Requests (TARs)

Since TARs can remain outstanding in the automated system for an extended length of time, Denti-Cal may deny authorization or payment of services based on an outstanding authorization. Denti-Cal may reconsider denial of authorization or payment of services that are duplicated on an outstanding TAR under the following circumstances:

- written notification from the beneficiary stating that he or she will not be returning to the original provider's office;
- closure of the original provider's office;
- sale of the original provider's practice;
- death of the original provider;
- refusal of the original provider to return the Notice of Authorization;
- treatment (such as extraction) was provided on an emergency basis by one dentist when authorization for the same treatment was granted previously to a different dentist.

For reconsideration of denial of authorization or payment under these circumstances, please follow these guidelines:

Obtain a written statement from the beneficiary that treatment will not be provided by the original dentist.

For an Explanation of Benefits (EOB) showing denial of payment: Attach the beneficiary's statement to the EOB and follow the normal procedures for the Claim Inquiry Form.

For a NOA showing denial of treatment authorization: Attach the beneficiary's statement and any other supporting documentation to the NOA, and submit the NOA with necessary radiographs to obtain reauthorization of the services. Denti-Cal will send the provider office a new NOA showing the allowed services and will void the original TAR.

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Notice of Denti-Cal Action

Denti-Cal sends all Denti-Cal beneficiaries and/or their authorized representatives written notification when services that require prior authorization have been denied, modified or deferred. The notification indicates the status of the TAR and explains why the requested service was denied, modified or deferred. Beneficiaries do not receive written notification of approved TARs or services that have been performed.

When the dental office prepares a TAR for a beneficiary with an authorized representative who is not identified on the BIC card, the representative's name and address should be included in the "Comments" box (Field 34) on page 2 of the Denti-Cal TAR form. This will assist Denti-Cal in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information. Denti-Cal must have a written authorization approving the person designated as the beneficiary's representative.

Beneficiaries may contact the provider for assistance with inquiries concerning their TARs. If the provider is unable to answer the beneficiary's questions, please refer them directly to Denti-Cal. A Denti-Cal beneficiary or authorized representative may call the Beneficiary Services toll-free telephone number at (800) 322-6384 for assistance with inquiries about denied, modified or deferred TARs.

Sample Notice of Denti-Cal Action

Denti-Cal

California Medi-Cal Dental Program

NOTICE DATE: MM/DD/YY

NOTICE OF DENTI-CAL ACTION
THIS IS NOT A BILL

BENEFICIARY, JANE 5498 PRIMROSE WAY ANYTOWN, CA XXXXX-XXXX	ADAMS, JAMES DDS INC 3157 MAIN ST STE 320 ANYTOWN, CA XXXXX-XXXX (XXX)XXX-XXXX

SERVICE OFFICE NAME:

MEDS ID: XXXXXXXXX
DCN: XXXXXXXXXXX
MRDCN: XXXXXXXXXXX

PAGE 1 OF 1
DATE OF REQUEST: MM/DD/YY
BENEFICIARY NAME: BENEFICIARY, JANE

Denti-Cal has processed your dentist's request for your treatment in accordance with Title 22, California Code of Regulations, Sections 51003, 51307, and the Manual of Criteria. At least one of the items cannot be approved or requires modification. Please refer to the enclosed list for an explanation of the REASON FOR ACTION CODE(S) listed. **In addition, specific minimum requirements can be found in the Denti-Cal Provider Handbook, under Section 5 entitled "MANUAL OF CRITERIA" under the specific Procedure Number listed below.** A copy may be found at any Medi-Cal Dentist's office.

Tooth # or Arch	Treatment Description	Procedure Number	Denti-Cal Action	Reasons for Action Code(s) (see enclosed for explanation)
	PARTIAL LOWER DENTURE - METAL	D5214	DENIED	19
14	ROOT CANAL, THREE ROOTS	D3330	APPROVED	
18	ROOT CANAL, THREE ROOTS	D3330	APPROVED	
29	TOOTH COLORED & METAL CROWN	D2750	DENIED	06
29	ROOT CANAL, TWO ROOTS	D3320	APPROVED	
LL	GUM TREATMENT	D4341	APPROVED	
LR	GUM TREATMENT	D4341	APPROVED	
UL	GUM TREATMENT	D4341	APPROVED	
UR	GUM TREATMENT	D4341	APPROVED	
29	TOOTH COLORED & METAL CROWN	D2750	DENIED	06

- You can discuss different treatment plans with your dentist to obtain the best care allowable under the Denti-Cal program.
- If you have a question regarding this action, please contact your dentist or Denti-Cal at 1-800-322-6384 for a more detailed explanation.
- **If you are dissatisfied with the action described in this notice, you may request a state hearing within 90 days from the Notice Date. Please see the back of this notice for information on filing a hearing.**

PO. Box 15539 ● Sacramento, CA 95852-1539 ● (800)322-6384

SAMPLE

IF YOU ARE DISSATISIFIED WITH THE ACTION DESCRIBED ON THIS NOTICE, YOU MAY REQUEST A STATE HEARING WITHIN 90 DAYS FROM THE NOTICE DATE.

To Request a Hearing:

Send this entire notice to:

Office of the Chief Administrative Law Judge

State Department of Social Services
Post Office Box 13189
Sacramento, CA 95813-3189

OR

You may call the TOLL-FREE number at the Public Inquiry and Response Unit. 1-800-952-253. (ASSISTANCE AVAILABLE IN LANGUAGES OTHER THAN ENGLISH)

State Regulations:

A copy of Title 22, California Code of Regulations, Sections 50951, 51014.1, and 51014.2, which covers state hearings, is available at your county social services office or local library.

Authorized Representative:

Your can represent yourself at the hearing or you can be represented by a friend, lawyer or any other person. You are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit or from your local social service office.

_____

☐ I WILL NEED A TRANSLATOR (at no cost to me).
MY LANGUAGE OR DIALECT IS:_____

SAMPLE

Resubmission Turnaround Document (RTD) (DC-102, Rev. 07/93)

An RTD is a computer-generated form used by Denti-Cal to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The form is divided into two sections:

Section “A” notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section “A” is assigned a letter of the alphabet under “field.” Section “A” is kept by the provider for office records.

Section “B” is the corrected information filled in by the provider. This section is returned to Denti-Cal.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

Upon receipt of the RTD, Denti-Cal matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

Note: If the RTD is not returned within the 45-day time limitation, the TAR, Claim or NOA will be denied according to Denti-Cal policies.

Sample Resubmission Turnaround Document (RTD)

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO DENTI-CAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDER HANDBOOK FOR FURTHER EXPLANATION.

BILLING PROVIDER NAME
MAILING ADDRESS
CITY, STE, ZIP CODE
ADAMS, JAMES DDS
30 MAIN STREET
ANYTOWN CA XXXXX-XXXX

MEDI-CAL PROVIDER NO.
XXXXXXXXX

NOTICE — PAGE 01 OF PAGES 01

RTD ISSUE DATE: 12-02-09
RTD DUE DATE: 01-16-09

PATIENT NAME	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.
LAST NAME FIRST NAME	XXXXXXXXX			662.00	01297102350

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		26	04		D7111	5	PROCEDURE REQUIRES TOOTH CODE

Sample

RETAIN THIS PORTION
DETACH ALONG THIS PERFORATION

DOCUMENT CONTROL NUMBER ● FOR DENTI-CAL USE ONLY

DENTI-CAL USE ONLY

DCN	CLAIM TYPE	PAGE	PAGES
01297102350	T	01 OF	01

BILLING PROVIDER NAME
ADAMS, JAMES DDS

MEDI-CAL PROVIDER NUMBER
XXXXXXXXXX

PATIENT NAME
LAST NAME FIRST NAME

PATIENT MEDI-CAL I.D. NUMBER
XXXXXXXXXX

This is to certify that the corrected information is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

X Mary Smith 12/19/09
SIGNATURE DATE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
	26	04	51	A TOOTH # 14

B

DC 102 (R 09/09)

RETURN THIS PORTION TO: **DENTI-CAL** P.O. BOX 15609, SACRAMENTO, CA 95852-0609

How to Complete the RTD

Section "A"

The information in Section "A" is computer-generated by Denti-Cal: it is retained by the provider.

The appropriate box (i.e. CLAIM, TAR, or NOA) will be checked to indicate the type of document submitted.

NOTE: Please read instructions carefully and verify the information in Section "A" is correct.

1. **BILLING PROVIDER NAME AND MEDI-CAL PROVIDER NUMBER**: As it appears on the document submitted by the provider's office.
2. **MAILING ADDRESS**: As it appears on the document submitted.
3. **CITY, STATE, ZIP CODE**: As it appears on the document submitted.
4. **PAGE __ OF __ PAGES**: A multi-page RTD may be issued for an individual TAR/ Claim form or NOA. Return all pages of the RTD in one envelope.
5. **RTD ISSUE DATE**: The RTD issue date. The RTD must be returned within 45 days of the RTD issue date.
6. **RTD DUE DATE**: The response due date. If not received by this date, the TAR, claim, or NOA will be denied.
7. **PATIENT NAME**: As it appears on the document submitted.
8. **PATIENT MEDI-CAL I.D. NUMBER**: As it appears on the document submitted.
9. **PATIENT DENTAL RECORD NUMBER**: As it appears on the document submitted.
10. **BEGINNING DATE OF SERVICE**: As it appears on the document submitted.
11. **AMOUNT BILLED**: As it appears on the document submitted.
12. **DOCUMENT CONTROL NO**.: The DCN assigned to the document submitted.
13. **ITEM**: The letter of the alphabet assigned by the computer to identify the line in Section "B" where the "Correct Information" should be entered.
14. **INFORMATION BLOCK**: The exact name of the field in question on the claim, TAR, or NOA.
15. **CLAIM FIELD NO**.: Indicates number corresponding to the information block on the claim, TAR, or NOA.
16. CLAIM LINE: The line number on the claim, TAR or NOA.
17. **SUBMITTED INFORMATION**: The description of the incorrect information submitted by the provider's office.
18. **PROCEDURE CODE**: Procedure codes as reported on the claim, TAR or NOA.
19. **ERROR CODE**: A code identifying the error that has been made on the claim, TAR or NOA.
20. **ERROR DESCRIPTION**: A description of the error that has been made on the claim, TAR or NOA.

Section "B"

This section is completed by the provider and returned to Denti-Cal.

1. **CORRECT INFORMATION**: Enter the correct information on the appropriate line in Section "B" corresponding to the information found in error in Section "A."
2. **SIGNATURE/DATE BLOCK**: The provider, or person authorized by the provider, must sign and date the form prior to its return. Lack of signature will result in disallowance of the document. Rubber stamp signatures are not acceptable.
3. **P.O.E./COMMENTS BLOCK**: This area may be used for any comments.

   Return the completed RTD to:

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

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Claim Inquiry Form (CIF)
(DC-003, Rev. 07/09)

The Claim Inquiry Form (CIF) is used to:

- inquire about the status of a Treatment Authorization Request (TAR) or Claim
- request re-evaluation of a modified or denied claim or Notice of Authorization (NOA) for payment

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. Please see "Claim Inquiry Response (CIR)" on page 6-33 for more information about CIRs.

CIF Tracer

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 Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Re-evaluations

A CIF claim re-evaluation is used to request the re-evaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the "Adjusted Claims" section.

Claim re-evaluations must be received within six (6) months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

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 Telephone Service Center at (800) 423-0507.

Sample Claim Inquiry Form (CIF)

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (E.O.B.)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call DENTI-CAL

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

1	BILLING PROVIDER NAME: ADAMS, JAMES DDS	2	MEDI-CAL PROVIDER NUMBER: XXXXXXXXXX
3	MAILING ADDRESS: 30 MAIN STREET		TELEPHONE NUMBER: (XXX) XXX-XXXX
4	CITY, STATE: ANYTOWN, CA		ZIP CODE: XXXXX-XXXX

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

5	PATIENT NAME (LAST, FIRST, M.I.)	6	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
7	PATIENT MEDI-CAL I.D. NUMBER	8	PATIENT DENTAL RECORD NUMBER (OPTIONAL)
		9	DATE FILED

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

10
- ☐ Claim for Payment. Attach a copy of form. Date of Service
- ☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

- ☐ Please re-evaluate modificiation/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional Information)

11

12

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

SIGNATURE _____ DATE _____

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR DENTI-CAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 07/09)

Sample

How to Complete the CIF

Use one CIF for each Claim or NOA. Please print or type all information:

1. **BILLING PROVIDER NAME**: Enter the billing provider's name in either the "doing business as" format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
2. **MEDI-CAL PROVIDER NUMBER**: Enter the Billing Provider Number (NPI). NOTE: The Provider Number must be present and correct on all forms.
3. **MAILING ADDRESS AND TELEPHONE NUMBER**: Enter the billing provider service office address where treatment is rendered. A service office address should be a street address, including city, state and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.

   If the service office address is different from the address where payment is received, then notify Denti-Cal so payment can be directed to the appropriate location.

   It is important to include the telephone number of the service office, including area code, so Denti-Cal can contact the provider if questions arise while processing the documents.
4. **CITY, STATE, ZIP CODE**: Enter the city, state, and zip code where the service office is located.
5. **PATIENT NAME**: Enter the beneficiary's last name, first name, and middle initial.
6. **DOCUMENT CONTROL NUMBER (CLAIM REEVALUATION ONLY)**: Enter the Document Control Number of the document in question. If you are inquiring about multiple claims submit one CIF only for each document in question.
7. **PATIENT MEDI-CAL ID NUMBER**: Enter the BIC or Client Index Number (CIN).
8. **PATIENT DENTAL RECORD NUMBER (OPTIONAL)**: If the provider assigns a Dental Record Number or Account Number to a beneficiary, enter the assigned number that will be referenced on any subsequent correspondence from Denti-Cal.
9. **DATE BILLED**: Enter the date the claim or the TAR was originally mailed to Denti-Cal.
10. **INQUIRY REASON - CHECK ONLY ONE BOX**: Indicate if this inquiry is seeking the status of a TAR or Claim ("tracer") or is requesting a reevaluation of a claim.
11. **REMARKS**: Use this area to provide any additional information needed to justify the inquiry being made. Include a copy of the claim, TAR, or NOA in question and any appropriate documentation, radiographs and photos. Attach all related radiographs/photos using the appropriate X-Ray envelope (i.e., the DC-214A or DC-214B).
12. **SIGNATURE and DATE**: The provider, or person authorized by the provider, must sign and date the form using blue or black ink. Rubber stamp signatures are not acceptable.

    Mail the form to:

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

Claim Inquiry Response (CIR)

Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Denti-Cal will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- beneficiary name
- beneficiary Medi-Cal identification number
- beneficiary Dental Record or account number, if applicable
- Document Control Number
- the date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR DENTI-CAL INQUIRY" will contain a status code and a typed explanation of that code. The status codes are listed in "Section 7: Codes" of this Handbook.

Sample Claim Inquiry Response (CIR)

DENTI-CAL
MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CA 95852-0609
(800) 423-0507

CORRESPONDENCE REFERENCE NUMBER ● FOR DENTI-CAL USE ONLY
XXXXXXXXXXXX

CLAIM INQUIRY RESPONSE

BILLING PROVIDER NAME / ADDRESS	MEDI-CALPROVIDER NUMBER
ADAMS, JAMES DDS	1234567891
30 CENTER STREET	TELEPHONE NUMBER
ANYTOWN CA 95814-0000	(XXX)XXX-XXXX

PATIENT NAME		DOCUMENT CONTROL NO.
LAST, FIRST		XXXXXXXXXXX
PATIENT MEDI-CAL I.D. NO.	PATIENT DENTAL RECORD NUMBER	DATE BILLED
XXXXXXXXX		

IN RESPONSE TO YOUR DENTI-CAL INQUIRY

STATUS CODE	EXPLANATION
02	CLAIM IN PROCECSS; AWAITING FINAL ADJUDICATION

Sample

ADDITIONAL EXPLANATION

BY: 0XX DATE: 09/15/09

Checklists

Before submitting a TAR, claim, or NOA to Denti-Cal for payment or authorization, follow this checklist:

1. **Submission for Claim (Payment) or TAR (Authorization)**
   Have you...
   a. Entered the NPI of the rendering provider who provided the services?
   b. completed an original TAR/Claim form?
   c. listed the date services were performed (if applicable)?
   d. indicated the place of service where the procedure was administered?
   e. attached radiographs/photographs?
   f. included any remarks or attachments necessary to document this payment/authorization request?
   g. affixed any paper attachments on a 8.5 x 11 piece of paper?
   h. placed any attachments behind the forms and stapled just once in the upper right hand corner?
   i. submitted only one-sided attachments?
   j. provided the appropriate signature and date in the signature block?
2. **Submission for NOA (For Payment).**
   Have you...
   a. listed the date of service?
   b. checked the "delete" column for services not performed?
   c. indicated any additions not requiring prior authorization?
   d. included any necessary radiographs/photographs or documentation?
   e. filled in all shaded areas, if applicable?
   f. affixed each paper attachment to an 8.5 x 11 piece of paper?
   g. placed any attachments behind the forms and stapled just once in the upper right hand corner?
   h. submitted only one-sided attachments?
   i. provided the appropriate signature and date in the signature block?
3. **Submission for NOA (For Reevaluation)**
   Have you...
   a. checked "Reevaluation is Requested" box at upper right corner?
   b. included radiographs/photographs or other documentation?
   c. enclosed your NOA in the appropriate mailing envelope?

Reminders

1. **Diagnostic Casts**

   Diagnostic casts are only for the evaluation of orthodontic benefits. Diagnostic casts submitted for all other procedures (crowns, prosthetics, etc.) will be discarded unless Denti-Cal specifically requested the models to evaluate the claim or authorization request.

   Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

   As diagnostic casts are not returned, please do not send originals.

2. **Paper Copies and Prints of Digitized Radiographs**

   Paper copies and prints of digitized radiographs should properly identify the beneficiary, the date the radiograph was originally taken, and the teeth/area in question. If not properly labeled, this could lead to processing delays as well as denial of treatment.

   Paper copies and digitized prints of radiographs must conform to the following specifications:

   a. They must be properly dated with the mmddyy the radiograph was originally taken. This date must be clearly discernible from other dates appearing on the same copy such as the date the copy was made or printed, or dates of previously stored digitized images.

   b. They must be properly labeled with both the beneficiary's name and the provider's name.

   c. If the individual teeth are not otherwise identified, copies or digitized prints of full mouth series radiographs and panographic

films must be labeled “right” and “left.” Copies of individual films or groups of films less than a full mouth series, should have the individual tooth numbers clearly identified.

d. They must be of diagnostic quality. Many of the copies/prints Denti-Cal receives have poor image quality as a result of poor density, contrast, sharpness, or resolution, and are, therefore, non-diagnostic. The image size should be the size of a standard radiographic film or larger. By reducing the image to be smaller than the size of a standard radiographic film, the diagnostic quality is compromised.

e. More than four sheets of paper are not acceptable

Providers should review copies/prints before submitting to Denti-Cal to ensure the images are of diagnostic quality.

3. State–Approved Forms.

Denti-Cal will only accept original State-approved forms. No duplicates or photo copies will be accepted or processed.

Time Limitations for NOAs

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, send the expired NOA back to Denti-Cal so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

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Justification of Need for Prosthesis (DC054, Rev 10/05)

The Justification of Need for Prosthesis Form (DC054) is designed to provide complete and detailed information necessary for screening and processing prosthetic cases. This form is required when submitting a Treatment Authorization Request (TAR) for complete dentures, immediate dentures, resin base partial dentures, cast metal framework partial dentures, and complete overdentures (Procedures D5110, D5120, D5211, D5212, D5213, D5214, and D5860).

Providers should document specific information describing the condition of the beneficiary's oral condition and the condition of any existing prosthetic appliances. Documentation must include:

- both arches;
- missing teeth;
- teeth to be extracted;
- teeth being replaced by the requested partial prosthesis (excluding third molars);
- teeth being clasped (applies to cast framework partial or resin base partial);
- the condition of the soft tissue and hard tissue, e.g., soft tissue inflammation, palatal torus, mandibular tori, atrophied ridge, large fibrous tuberosity, hyperplastic tissue, etc.

It is the provider's responsibility to document conditions that Denti-Cal will need for determining the beneficiary's need for the initial placement or replacement of a prosthesis as well as their ability to adapt to a prosthesis.

If a provider fails to submit a Justification of Need for Prosthesis Form, Denti-Cal will issue an RTD for the required form, which will delay processing of the request. If the information on the Justification of Need for Prosthesis is incomplete or contradictory, the requested prosthetic appliance(s) will be denied.

The Justification of Need for Prosthesis Form is provided and may be ordered from the Denti-Cal forms supplier free of charge. A sample and instructions for completing the form are as follows:

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

3 Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD

4 Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD ☐ Never had a maxillary prosthetic appliance

Wears appliance? ☐ Yes ☐ No Age of Appliance: _____

Catastrophic Loss? ☐ Yes ☐ No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.

If lost in facility or hospital, explain circumstances: _____

MANDIBULAR ARCH

Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD

Existing Appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD ☐ Never had a mandibular prosthetic appliance

Wears appliance? ☐ Yes ☐ No Age of Appliance: _____

Catastrophic Loss? ☐ Yes ☐ No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.

If lost in facility or hospital, explain circumstances: _____

5

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	☐	☐	_____
Framework	☐	☐	_____
Denture Teeth	☐	☐	_____
Retention	☐	☐	_____
Soft Tissue	☐	☐	_____
Hard Tissue	☐	☐	_____
Opposing Dentition	☐	☐	_____
Centric Occlusion	☐	☐	
Vertical Relation	☐	☐	Open ____ mm Closed ____ mm

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	☐	☐	_____
Framework	☐	☐	_____
Denture Teeth	☐	☐	_____
Retention	☐	☐	_____
Soft Tissue	☐	☐	_____
Hard Tissue	☐	☐	_____
Opposing Dentition	☐	☐	_____

Edentulous ☐ Maxillary ☐ Mandibular

6

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 ○ **Circle teeth to be extracted**

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

7

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

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

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

9 Does the patient want requested services? ☐ No ☐ Yes

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

11 **ADDITIONAL COMMENTS:** _____

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

13 Provider Signature _____ License # _____

DC 054 (R10/05)

Sample

How to Complete the Justification of Need for Prosthesis Form

1. **PATIENT NAME**: Enter the beneficiary's name exactly as it appears on the Medi-Cal 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.

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, then 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.

Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC-016, Rev 06/09)

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider **Patient**

Name:_____ **Name:**_____

Number:_____

Date:_____

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT.

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation) Indicate an 'X' if present and score no further ..... _____
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist) Indicate an 'X' if present and score no further ..... _____
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.** Indicate an 'X' if present and score no further ..... _____
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT** Indicate an 'X' if present and score no further ..... _____
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) Indicate an 'X' if present and score no further ..... _____

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Indicate an 'X' if present and score no further ..... _____

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm ..... _____

7. Overbite in mm ..... _____
8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm ..... _____ x 5 = _____
9. Open bite in mm ..... _____ x 4 = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ (tooth numbers) _____ (total) x 3 = _____
11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ (maxilla) _____ (mandible) _____ (total) x 5 = _____
12. Labio-Lingual spread in mm ..... _____
13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite) ..... Score 4 _____

TOTAL SCORE: _____

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT–SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐ **EPSDT–SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.)

DO NOT WRITE IN THIS AREA.

a) Principal diagnosis and significant associated diagnosis; and
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

DC016 (R 06/09)

Sample

How to Complete the HLD Index Scoresheet

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION
SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A **Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)

6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

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Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement which accompanies each check sent to Denti-Cal providers. It lists all paid and denied claims that have been adjudicated or adjusted during the payment cycle, as well as non-claims specific information. Claims and TARs that have been in process over 18 days are also listed.

Lost/Misplaced EOBs

Providers are issued an EOB each week which lists, in detail, all activity on documents for accounting and tracking purposes. Listed on the weekly EOB are all paid claims, adjustments and current status of pending documents. In addition, the EOB contains seminar information, accounts payable and receivable activity, and notification of electronic funds transfer information.

Each service office with claim activity receives an EOB which should be used for payment posting, account balancing, and monitoring the progress of documents in process as they go through the system. Service offices managed through corporate offices should have internal procedures in place to ensure they receive the most current information relative to their submissions, i.e., FAX, scanned e-mail, etc.

Lost or misplaced EOBs can be reprinted at a cost of ten cents ($.10) per page. For multiple EOB requests requiring research and restoration there is an additional cost for labor of ten dollars ($10.00) per hour. Please submit your request in writing, including your provider number and the EOB issue date to:

Denti-Cal
Attn: Provider Services General Correspondence
PO Box 15609
Sacramento, CA 95852-0609

Sample Explanation of Benefits (EOB)

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

1 LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

2 LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

3 PROVIDER: No

4

5 CHECK: No

6 DATE:

7 PAGE NO.

8 STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

9 BENEFICIARY NAME	10 MEDI-CAL I.D. NO.	11 BENE ID	12 SEX	13 BIRTH DATE

C DOCUMENT CONTROL NO. 14	TOOTH CODE 15	PROC. CODE 16	DATE OF SERVICE 17	STA-TUS 18	REASON CODE 19	AMOUNT BILLED 20	ALLOWED AMOUNT 21	SHARE OF COST 22	OTHER COVERAGE 23	AMOUNT PAID 24

Sample

25 CLAIMS SPECIFIC		26 NON CLAIMS SPECIFIC			27
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

How to Read the EOB

Following is an explanation of each item shown on the sample EOB. Each item is numbered to correspond with those numbers on the sample EOB.

1. **REFERENCE LINES PRECEDED BY A "B"**: contains beneficiary's information.
2. **REFERENCE LINES PRECEDED BY A "C"**: contains claim information for the listed beneficiary.
3. **PROVIDER NO.**: The billing provider's NPI.
4. **PROVIDER'S NAME AND ADDRESS**: The provider's name and billing address.
5. **CHECK NO.**: Number of the check issued with the EOB.
6. **DATE**: Date EOB was issued.
7. **PAGE NO.**: Page number of the EOB.
8. **STATUS CODE DEFINITION**: The status code used to identify each claim line. "P" = Paid, "D" = Denied, "A" = Adjusted.
9. **PATIENT NAME**: Each beneficiary is listed once per category.
10. **MEDI-CAL I.D. NO.**: The beneficiary 's Medi-Cal identification number.
11. **BENE ID**: The beneficiary's BIC or CIN.
12. **SEX**: The sex code for each beneficiary, "M" = male, "F" = female.
13. **BIRTHDATE**: Birthdate of each beneficiary.
14. **DOCUMENT CONTROL NUMBER (DCN)**: The number assigned to each claim by Denti-Cal.
15. **TOOTH CODE**: Lists the tooth number, letter, arch or quadrant on which the procedure was performed.
16. **PROC. CODE**: The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.
17. **DATE OF SERVICE**: The date the service was performed.
18. **STATUS**: Identifies the status of each claim line. The status codes are explained in "Section 7: Codes" of this Handbook.
19. **REASON CODE**: The code explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied. The reason codes and a written explanation of each one are printed on the EOB.
20. **AMOUNT BILLED**: The amount billed for each claim line.
21. **ALLOWED AMOUNT**: The amount allowed for each claim line; this amount is the lesser of the billed amount or the amount allowed by the Schedule of Maximum Allowances.
22. **SHARE-OF-COST**: The amount the beneficiary paid towards a share-of-cost obligation.
23. **OTHER COVERAGE**: The amount paid by another carrier or by Medicare.
24. **AMOUNT PAID**: The total amount paid to a provider after deductions, if applicable, as shown in numbers 22 and 23.
25. **CLAIMS SPECIFIC**: Only printed on the last page of the EOB. These amounts are the totals for all adjudicated claim lines listed on the EOB.
26. **NON-CLAIMS SPECIFIC**: The (a) payables amount; (b) levy amounts, (c) accounts receivable amounts. Only printed on the last page of the EOB.
27. **CHECK AMOUNT**: The amount of the check that accompanies this EOB.

Sample Paid Claim, Levy

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

No **CHECK** **XXXXXXXX**

TAX ID NO: **xxxxxxxxx-** **DATE:** **mm/dd/yy** **PAGE NO.** **x** **OF** **x**

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

(12) LEVIES (AMOUNT WE PAID FOR YOU)

CHECK-NO	HOLDER-NO	NAME OF LEVEY HOLDER	AMOUNT
400012908	000000123	LEVY HOLDER	-100.00
		* TOTAL LEVIES	-100.00

Sample

(13) CLAIMS SPECIFIC		(14) NON CLAIMS SPECIFIC			(15)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
155.00	.00	.00	100.00	.00	55.00

How to Read the Paid Claim with Levy Deduction EOB

1.-11. This information, printed on each page of the EOB, is explained on a preceding page entitled "How to Read the EOB."

12. **LEVIES (AMOUNTS DENTI-CAL PAID FOR THE PROVIDER)**: When an EOB reflects a levy deduction, the levy amount is shown with the following information:

    Check Number - The number of the check issued to the levy holder by Denti-Cal.

    Holder Number - The number issued by Denti-Cal to the levy holder upon receipt of a levy request.

    Name of Levy Holder - The name of the levy holder, e.g., the Internal Revenue Service.

    Amount - The amount of the payment issued to the levy holder by Denti-Cal, shown as a negative amount. The levy amount shown in the sample is deducted from the check issued to the provider referenced on this EOB.

13. **CLAIMS SPECIFIC**: Lists the totals for all adjudicated claim lines listed on the sample.
14. **NON CLAIMS SPECIFIC**: This area on the sample shows the levy amount ($100.00) deducted from the amount of the check issued to the provider which corresponds to this EOB.
15. **CHECK AMOUNT**: The amount shown for this check ($55.00) reflects the Claims Specific Amounts paid listed in Field 13 ($155.00) minus the Non Claims Specific Levy Amount Shown in Field 14 ($100.00).

Sample Levy Payment

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

No **CHECK**
XXXXXXXX

TAX ID NO:
XXXXXXXXX-

DATE: **mm/dd/yy** **PAGE NO.** **x** **OF** **x**

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

THE ENCLOSED CHECK IS IN PAYMENT ON THE FOLLOWING LEVY HELD BY YOU:

1 LEVY NBR	2 ACCOUNT OF	3 NPI/TAX-ID	4 CHECK NO.
000000083	JAMES ADAMS	XXXXXXXXXX	010300764

5 AMOUNT OF PAYMENT

50.00

Sample

6

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
					55.00

How to Read the Levy Payment EOB

This is an example of an EOB that would accompany a levy payment to a levy holder, e.g., the Internal Revenue Service, made by Denti-Cal on behalf of the provider.

1. **LEVY NBR**: The number issued by Denti-Cal that identifies the levy.
2. **ACCOUNT OF**: The name of the provider for whom the levy payment is being made.
3. **NPI/TAX ID**: The National Provider Identifier or Tax Identification Number of the provider for whom the levy payment is being made.
4. **CHECK NO**.: The number of the check, issued to the provider, from which the levy payment is deducted. The provider's EOB will identify the number of the check issued to the levy holder, the levy number, the name of the levy holder, and the amount of the levy payment issued.
5. **AMOUNT OF PAYMENT**: Shows the amount of the payment to the levy holder.
6. **CHECK AMOUNT**: The amount of the check sent by Denti-Cal to the levy holder.

Sample Documents In-Process

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No XXXXXXXXXX

CHECK
No XXXXXXXX

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

DATE: mm/dd/yy PAGE NO. x of x

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BEND ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

1 DOCUMENTS IN-PROCESS

2 LAST NAME	3 FIRST NAME	4 MEDI-CAL ID	5 BENE - ID	6 DOB	7 DCN	8 AMT BILLED	9 *CODE	
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08168108450	567.00	C	IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	08169103850	423.00	T	CS
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08175100684	112.00	C	IR

10 TOTAL DOCUMENTS IN-PROCESS 3 11 TOTAL BILLED 1102.00

12 * THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR REEVALUATION

DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR X RAYS/ATTACHMENTS WAS SENT TO PROVIDER)
RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

++

13 THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN ON 09/10/08 FROM 9:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

14 THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON 09/11/08 FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN ON 10/15/08 FROM 9:00 AM TO 4:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

SAMPLE

How to Read the Documents In-Process EOB

The "Documents In-Process" section printed on the EOB will list information on all in-process documents grouped together by type of document (C = Claim, N = NOA, T = TAR, and R = TAR Reevaluation) and in-process status (professional review, state review, information required, etc).

1-8 **DOCUMENTS-IN-PROCESS**: Information listed in these areas of the sample is a description of each document that has been "in process" for 18 days or longer.

9. **CODE**: The appropriate code listed indicates the reason that the claim is "in process."
10. **TOTAL CLAIMS IN PROCESS**: The example shows the total number of documents "in process."
11. **TOTAL BILLED**: Total billed amounts for the documents "in process."
12. The last page of the EOB containing in-process documents information provides a legend listing the reason codes for documents in process. Beside each code is a printed explanation which defines the reason a particular document is "in process."
13. Denti-Cal notifies the provider of upcoming provider training seminars with a message appearing at the end of the Explanation of Benefits (EOB) statement.
14. The location of the training seminar(s) nearest the provider's office is determined automatically and will be printed on the EOB.

Sample Accounts Receivable

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

NOT ISSUED REF

TAX ID NO:
XXXXXXXXX-

CHECK
No **XXXXXXXX**

DATE: **mm/dd/yy** **PAGE NO.** **x** **OF** **x**

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

RECEIVABLES (AMOUNT YOU OWE US):
******* THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS:

2 EFFECTIVE DATE	3 PRINCIPAL BALANCE	4 INTEREST APPLIED	5 PD,VOID,OR TRANSFERRED	6 CURRENT BALANCE	7 TRANSACTION TYPE
1 A/R NBR: 01907	8 REMARKS: INTERNAL ADJUSTMENT				
08/01/08	600.00	0.00	0.00	0.00	
	600.00	0.00	0.00	0.00	

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC (9)			(10)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	.00	.00	.00	600.00

How to Read the Accounts Receivable (AR) EOB

1. **A/R NBR**: The number assigned by Delta Dental that identifies the accounts receivable (the amount the provider owes Delta).
2. **EFFECTIVE DATE**: The date the accounts receivable was created.
3. **PRINCIPAL BALANCE**: The amount of the accounts receivable when it was created.
4. **INTEREST APPLIED**: If applicable, is the amount of interest applied to the outstanding A/R. Always factored in, it is now recorded
5. **PD, VOID, OR TRANSFERRED**: The amount the provider has paid or that has been deducted from the provider's check towards the accounts receivable.
6. **CURRENT BALANCE**: The current amount the provider owes on the accounts receivable.
7. **TRANSACTION TYPE**: If applicable, this reflects the type of payment transaction(s).
8. **REMARKS**: This area provides an explanation for the accounts receivable. In this example, Delta issued an overpayment to the provider for a document with DCN 98104100330.
9. **NON CLAIMS SPECIFIC A/R AMOUNT**: The total of the accounts receivable listed on the EOB or the amounts owed by the provider.
10. **CHECK AMOUNT**: The final amount of the check issued to the provider that corresponds to this EOB.

Sample Accounts Payable

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No XXXXXXXXXX

TAX ID NO: XXXXXXXXX-

CHECK
No XXXXXXXX

DATE: mm/dd/yy PAGE NO. x OF x

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B

BENEFICIARY NAME	MEDI-CAL I.D. NO.	BENE ID	SEX	BIRTH DATE

C

DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

RECEIVABLES (AMOUNT YOU OWE US):

******* THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS.

PAYABLES/CASH RECEIPTS (AMOUNTS OWED TO YOU/PAID BY YOU)

1 PAYABLE NUMBER	2 REASON CODE	3 DESCRIPTION	5 AMOUNT
0000435	5	PAYABLE	50.00
0000436	5	4 CHECK # 123456 APPLIED TO ACCOUNT	50.00

6 TOTAL OF CHECK NUMBER 000123456 50.00

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC (7)			8
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	100.00	.00	.00	100.00

How to Read the Accounts Payable (AP) EOB

1. **PAYABLE NUMBER**: The number assigned by Delta Dental that identifies the accounts payable (the amounts Delta owes the provider).
2. **REASON CODE**: The code that identifies the reason for the payable. See "Section 7: Codes" of this Handbook for the AR/AP Reason Codes and Descriptions.
3. **DESCRIPTION**: An explanation of the transaction.
4. **CHECK #**: The number of the check that the provider sent to Delta.
5. **AMOUNT**: Lists the dollar amount of each payable listed on the EOB.
6. **TOTAL OF CHECK NUMBER**: The amount of the check the provider sent to Delta.
7. **NON CLAIMS SPECIFIC PAYABLES AMOUNT**: The total amount of the provider accounts payable shown on this EOB.
8. **CHECK AMOUNT**: The final amount of the check issued to the provider that corresponds to this EOB.

Sample Readjudicated Claim

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER No **XXXXXXXXXX**

CHECK No **XXXXXXXX**

DATE: mm/dd/yy PAGE NO. x of x

Adams, James, DDS
30 Center Street
Anytown, CA 95814

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

	BENEFICIARY NAME	MEDI-CAL I.D. NO.	BENE ID	SEX	BIRTH DATE
B					

	DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID
C											

ADJUSTMENT CLAIMS

B	LAST	FIRST					99999999D	99999999D		F		mm/dd/yy
C	#30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C	08168101357	15	D7210	06/10/08	A	266B	- 95.00	- .00				- .00
C		14	D2140	06/10/08	A	(1)	- 50.00	- 39.00	(2)		(3)	- 39.00
C		13	D2140	06/10/08	A		- 50.00	- 39.00				- 39.00
	CLAIM TOTAL						- 195.00	- 78.00				- 78.00
B	LAST	FIRST					99999999D	99999999D		F		mm/dd/yy
(4) C	#30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C	08168101357	15	D7210	06/10/08	P	(5)	95.00	85.00	(6)		(7)	85.00
C		14	D2140	06/10/08	P		50.00	39.00				39.00
C		13	D2140	06/10/08	P		50.00	39.00				39.00
	CLAIM TOTAL						195.00	163.00				163.00
(8)	*TOTAL ADJUSTED CLAIMS						.00	85.00				85.00
	**PROVIDER CLAIMS TOTAL						132.00	186.00				186.00

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00	.00	.00	.00	186.00

How to Read the Readjudicated Claim EOB

The original claim is described in the top section of the "ADJUSTMENT CLAIMS" section of the sample. The description of the results of the readjudication of the previously processed claim is found in the lower portion of the "ADJUSTMENT CLAIMS" section. The areas on the sample EOB that distinguishes the original claim information from the readjudicated claim information is as follows:

Original Claim Information

1. The status code "A" indicates this claim service line on the original claim was allowed.
2. The amount that was allowed for this claim service line when the claim service line was originally processed.
3. The amount of the payment that was made to the provider for this claim service line when the claim was originally processed by Denti-Cal.

Readjudicated Claim Information

4. The code and description indicate why the claim was readjudicated. Descriptions of Readjudication Codes and Messages (Claim Correction Codes) can be found in "Section 7: Codes" of this Handbook.
5. The status code "P" indicates the claim service line was "paid" after readjudication.
6. This amount ($85.00) shows the amount allowed for this claim service line after readjudication.
7. The amount listed is the total amount paid to the provider for the readjudicated claim service line.
8. Total adjusted claims: This line shows the amounts allowed and to be paid to the provider after the claim was readjudicated.

Section 7 - Codes

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Section 7 - Codes

Adjudication Reason Codes

In adjudicating claim and TAR forms, it is sometimes necessary to clarify the criteria for dental services under the Denti-Cal Program. These processing policies are intended to supplement the criteria. The Adjudication Reason Code is entered during processing to explain unusual action taken (if any) for each claim service line. These codes will be found on Explanations of Benefits (EOBs) and Notices of Authorization (NOAs).

Welfare and Institutions (W&I) Code 14132.88(f), amended by AB 1762, Chapter 230 (2003-2004), requires pretreatment radiograph documentation for post treatment claims to establish the medical necessity for dental restorations (fillings and prefabricated/stainless steel crowns) and to reduce fraudulent claims for unnecessary restorative services.

ARC #	Adjudication Reason Code Description
	DIAGNOSTIC/PREVENTIVE
001	Procedure is a benefit once per patient, per provider.
001A	An orthodontic evaluation is a benefit only once per patient, per provider.
002	Procedure is a benefit once in a six-month period for patients under age 21.
002A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for patients under age 21.
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.
006	Procedure is a benefit once per tooth.
008	Procedure was not adequately documented.
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.
010	Procedure 020 not a benefit in conjunction with Procedure 030.
011	Procedure 030 is payable only once for a visit to a single facility or other address per day regardless of the number of patients seen.
011A	Procedure 030 is payable only when other specific services are rendered same date of service.
012	Procedure 030, time of day, must be indicated for office visit.
012A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030
013	Procedure requires an operative report or anesthesia record with the actual time indicated.
013A	Procedure has been authorized. However, the actual fee allowance cannot be established until payment is requested with the hospital time documented in operating room report.
013B	Procedure D9410 is not payable when the treatment is performed in the provider's office or provider owned ambulatory surgical center.
013C	The anesthesia record must be signed by the rendering provider and the rendering provider's name and permit number must be printed and legible.
013D	The treating provider name on the anesthesia record does not coincide with the Rendering Provider Number (NPI) in field 33 on the claim.
013E	The treating provider performing the analgesia procedure must have a valid permit from the DBC and the permit number must be on file with Denti-Cal.
014	Procedure is not a benefit to an assistant surgeon.
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.

ARC #	Adjudication Reason Code Description
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
020A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
020B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
020C	Prophy and flouride procedures are allowable once in a six month period.
020D	Prophy and flouride procedures are allowable once in a 12 month period.
020E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
020F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
020G	Topical application of fluoride is payable only for caries control.
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.
022	Full mouth or panographic X-rays are a benefit once in a three year period.
023	A benefit twice in a six-month period per provider.
024	A benefit once in a 12-month period per provider.
024A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
024B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
024C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
024D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.
024E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
024F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.
027	Procedure is not a benefit for edentulous areas.
028	A benefit once in a six-month period per provider.
028A	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
028B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
029	Payment/Authorization denied due to multiple unmounted radiographs.
029A	Payment/Authorization denied due to undated radiographs or photographs.
029B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.
029C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.

ARC #	Adjudication Reason Code Description
029D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.
029E	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative
029F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.
029G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
029H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.
030	An adjustment has been made for the maximum allowable radiographs.
030A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
030B	Combination of radiographs is equal to a complete series.
030C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.
030D	Periapicals are limited to 20 in any consecutive 12-month period.
031	Procedure is payable only when submitted.
031A	Photographs are a benefit only when appropriate and necessary to document associated treatment.
031B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.
031C	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
031D	Photographs are not payable when the date does not match the date of service on the claim.
032A	Endodontic treatment and postoperative radiographs are not a benefit.
032B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
032C	X-rays disallowed for the following reasons: X-rays appear to be of another person.
032D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.
033A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
034	Emergency procedure cannot be prior authorized.
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
038	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free
039	Dental sealants are only payable when the occlusal surface is included.
039A	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
	ORAL SURGERY
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
043A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedure(s).
044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.

ARC #	Adjudication Reason Code Description
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
046A	Post-operative visits are not payable after 30 days following the surgical procedure.
047	Post operative care within 90 days by the same provider is not payable.
047A	Post operative care within 30 days by the same provider is not payable.
047B	Post operative care within 24 months by the same provider is not payable.
048	Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
049	Extractions are not payable for deciduous teeth near exfoliation.
050	Surgical extraction procedure has been modified to conform with radiographic appearance.
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
054A	Procedure is not a benefit within six months of extractions in the same quadrant.
054B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.
058	Procedure is a benefit for anterior permanent teeth only.
059	Procedure allowed per Current Procedural Terminology (CPT) code description.
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
	DRUGS
063	Only the most profound level of anesthesia is payable per date of service. This procedure is considered global and is included in the fee for the allowed anesthesia procedure.
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.
066	The need for 301 must be justified and documented.
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.
069	Procedure is not a benefit when all additional services are denied or when there are no additional services submitted for the same date of service.
070	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.
071	Procedure 400 is not a benefit when the surgical procedures are performed in a hospital or surgicenter.
	PERIODONTICS
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.
073	Periodontal chart not current.
073A	Periodontal chart not current. Older than 14 months.

ARC #	Adjudication Reason Code Description
073B	Periodontal chart not current. Periodontal treatment performed after charting date.
073C	Periodontal chart not current. Charting date missing or illegible.
073D	Periodontal chart not current. Charting date invalid or dated in the future.
073E	Periodontal chart not current. Older than 12 months
074A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.
074B	Periodontal procedure disallowed due to inadequate charting of: Mobility.
074C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.
074D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.
076	A benefit twice in a 12-month period per provider.
077	Periodontal procedures 452, 472, 473, and 474 are not benefits for beneficiaries under 18 years of age except for cases of drug-induced hyperplasia.
077A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.
079	Multiples of Procedure 452 must be performed on different days.
080	A prophy or prophy and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.
081	Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs.
081A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.
083A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.
085A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.
085B	Only one Scaling and Root Planing, or Perio Maintenance or Prophylaxis procedure is allowable within the same calendar quarter.
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
086A	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
087A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
087B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.
088	Procedure is a benefit once per quadrant every 24 months.
088A	Procedure is a benefit once per quadrant every 36 months.
089	Procedure is not a benefit for periodontal grafting.

ARC #	Adjudication Reason Code Description
	ENDODONTICS
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
091A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.
092	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary post operative care within 90 days.
093A	Endodontic procedure is not payable when root canal filling underfilled.
093B	Endodontic procedure is not payable when root canal filling overfilled.
093C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.
093D	Endodontic procedure is not payable when: Root canal filling is undercondensed.
093E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
093F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
096	Procedure not a benefit in conjunction with a full denture or overdenture.
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
098	Procedures 530 and 531 include retrograde filling.
099	A benefit once per tooth in a six-month period per provider.
100	Procedure is not a benefit for an endodontically treated tooth.
101	This procedure requires a prerequisite procedure.
101A	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.
	RESTORATIVE
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
113A	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
113B	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.

ARC #	Adjudication Reason Code Description
113C	Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.
113E	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
113F	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a pre-fabricated or laboratory processed crown and the need for the restoration is not justified.
114	Tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures are included in the fee for a completed restorative service.
115	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
116	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspids.
117	Procedure not a benefit for a primary tooth near exfoliation.
118	Proximal restorations in anterior teeth are paid as single surface restorations.
119	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
120	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
121	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
121A	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
122	Tooth does not meet the Manual of Criteria for a prefabricated crown.
123	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
124	Radiograph or photograph indicate additional surface(s) require treatment.
124A	Decay not evident on requested surface(s), but decay evident on other surface(s).
125	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.
125A	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.
125B	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
126	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.
127	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
128	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
131	Procedure is a benefit only in cases of extensive coronal destruction.
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
133	Procedure not allowed due to denial of a root canal filled with silver points.

ARC #	Adjudication Reason Code Description
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed; i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
136	Procedure not a benefit for prefabricated crowns.
	PROSTHODONTICS
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
146	A removable partial denture includes all necessary clasps, rests and teeth.
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
148	Sufficient teeth are present for the balance of the opposing prosthesis.
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
149A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
151	This procedure is not a benefit for a resin base partial denture.
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).
153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.
155	Procedure requires a properly completed prosthetic DC054 form.
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.
157	A laboratory invoice is required for payment.
160	Laboratory or chairside relines are a benefit once in a 12 month period per arch.
161	Procedure 722 is a benefit once in a 12-month period per arch.
161A	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.
161B	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.
162	Patient's existing prosthesis is adequate at this time.
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).
164	Prosthesis serviceable by laboratory reline.
165	Existing prosthesis can be made serviceable by denture duplication ("jump", "reconstruction").

ARC #	Adjudication Reason Code Description
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
168A	Patient does not wish extractions or any other dental services at this time.
168B	Patient has selected different provider for treatment.
169	Procedure 723 is limited to two per appliance in a full 12 month period.
169A	Procedure is limited to two per prosthesis in a 36-month period.
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.
172	Payment for a prosthesis is made upon insertion of that prosthesis.
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five year period.
174	Procedure 724 is a benefit only when the existing denture is at least two years old.
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.
175A	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.
176	Per radiographs, insufficient tooth space present for the requested procedure.
177	New prosthesis cannot be authorized. Patient's dental history shows prosthesis made in recent years has been unsatisfactory for reasons that are not remediable.
178	The procedure submitted is no longer a benefit under the current criteria manual. The procedure allowed is the equivalent to that submitted under the current Schedule of Maximum Allowances and criteria manual.
179	Procedure requires prior authorization and cannot be considered as an emergency condition.
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.
	SPACE MAINTAINERS
190	Radiographs do not depict the erupting permanent tooth/teeth.
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.
194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.
195	A space maintainer is not a benefit for the upper or lower anterior region.
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.
197	Procedure requested is not a benefit when only one tooth space is involved or qualifies. Maximum benefit has been allowed.
197A	Procedure is only a benefit to maintain the space of a single primary molar.
	ORTHODONTIC SERVICES
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200A	Adjustments of banding and/or appliances are allowable once per quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.

ARC #	Adjudication Reason Code Description
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
	MAXILLOFACIAL SERVICES
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12 month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.

ARC #	Adjudication Reason Code Description
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon's provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: "CCS approved" stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.
	MISCELLANEOUS
258	Functional limitations or health condition of the patient preclude(s) requested procedure.
259A	Procedure not a benefit within 6 months to the same provider.
259B	Procedure not a benefit within 12 months to the same provider.
259C	Procedure not a benefit within 36 months to the same provider.
259D	Procedure not a benefit within 24 months to the same provider.
259E	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
260	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
261	Procedure is not a benefit of this program.
261A	Procedure code is missing or is not a valid code.
261B	CDT codes are not valid for this date of service.
261C	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
262	Procedure requested is not a benefit for children.
263	Procedure requested is not a benefit for adults.

ARC #	Adjudication Reason Code Description
264	Procedure requested is not a benefit for primary teeth.
265	Procedure requested is not a benefit for permanent teeth.
266A	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
266B	Payment and/or prior authorization disallowed. Lack of radiographs.
266C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
266D	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
266E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
266F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
266G	Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.
266H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.
266I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
266J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
266K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
266L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
266M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
266N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
267	Documentation not submitted.
267A	Description of service, procedure code and/or documentation are in conflict with each other.
267B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.
267C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.
267D	Documentation insufficient/not submitted. Study models not submitted.
267E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.
267F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
267G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
267H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
267I	Documentation submitted is incomplete.
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
268A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.
268B	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.

ARC #	Adjudication Reason Code Description
268C	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate fo a FRADS that may be a covered benefit.
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
269B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
269C	Procedure denied for the following reason: Associated with another denied procedure.
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
271A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
271B	Procedure is disallowed due to the following: Apical radiolucency.
271C	Procedure is disallowed due to the following: Arch lacks integrity.
271D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
271E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
271F	Procedure is disallowed due to the following: Gross destruction of crown or root.
271G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.
271H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
271I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
271J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.
272	Tooth not present on radiograph.
272A	Per radiograph, tooth is unerupted.
272B	Radiographs and/or documentation reveals that tooth number may be incorrect.
273	Procedure denied as beneficiary is returning to original provider.
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.
274A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
274B	Authorized treatment plan has been altered; therefore, payment is disallowed.
274C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
274D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
278	Preventive control programs are included in the global fee.
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
280	Not payable when condition is asymptomatic.
281	Services solely for esthetic purposes are not benefits.
282	By-report procedure documentation missing or insufficient for payment calculations.
283	Payment amount determined from documentation submitted for this by-report procedure.

ARC #	Adjudication Reason Code Description
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.
284A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
284B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.
284C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
284D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
284E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.
285	Procedure does not show evidence of a reasonable period of longevity.
285A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
286	Procedure previously rendered.
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
287A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.
288	Procedure cannot be considered an emergency.
289	Procedure requires prior authorization.
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
291	Per date of service, procedure was completed prior to date of authorization.
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.
293A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
293C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.
294A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
297	Procedure 803 not covered as a separate item. Global fee where a benefit.
298	A fee for completion of forms is not a covered benefit.
299	Complete denture procedures have been rendered/authorized for the same arch.
299A	Extraction procedure has been rendered/authorized for the same tooth.
300	Procedure recently authorized to your office.

ARC #	Adjudication Reason Code Description
300A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.
303A	Fixed Partial Dentures are not a benefit when the number of missing teeth in the posterior quadrant(s) do not significantly impact the patient's masticatory ability.
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.
305	Procedure not a benefit for tooth/arch/quad indicated.
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.
307A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.
307B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.
308	Procedure disallowed due to a beneficiary identification conflict.
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.
	PAYMENT POLICY
312	Certified orthodontist not associated to this service office.
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.
313A	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No other coverage EOB/RA, fee schedule or proof of denial submitted.
313B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
313C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
313D	Study models submitted are non-diagnostic, untrimmed, or broken.
313E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.
314A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
314B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
314C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.
314D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
314E	Per radiographs or documentation, please re-evaluate for: Procedure 706
314F	Per radiographs or documentation, please re-evaluate for: Procedure 708
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.
316	Payment disallowed. Request received over 12 months from end of month service was performed.
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).

ARC #	Adjudication Reason Code Description
317A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
317B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).
318	Recipient eligibility not established for dates of services.
318A	Recipient eligibility not established for dates of services. Share of cost unmet.
319	Rendering or billing provider NPI/ID not on file.
319A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.
320	Rendering or billing provider not enrolled for date of service.
320A	Rendering or billing provider is not enrolled as a certified orthodontist.
320B	The billing provider has discontinued practicing at this office location for these Dates of Service.
321	Recipient benefits do not include dental services.
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.
326	Procedures being denied on this document due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document.
326A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.
327	Payment cannot be made; our records indicate patient deceased.
328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.
330A	Beneficiary is not eligible for Medi-Cal dental benefits. Verify beneficiary's enrollment in Healthy Families which may include dental benefits.
331	Authorized services are not a benefit if patient becomes ineligible during authorized period and services are performed after the patient has reached age 18 without continuing eligibility.
332	Share of cost patient must pay for these services.
333	Payment cannot be made for procedures with dates of service after receipt date.
333A	Payment disallowed. Date of service is after receipt date of first NOA page(s).
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.
335	Billing provider name does not match our files; payment/ authorization cannot be made.
336	Beneficiary is not eligible for dental benefits.
337	The procedure is not a benefit for the age of the beneficiary.
337A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.

ARC #	Adjudication Reason Code Description
338	This service will be processed under the former contract separately.
339	The POE label on the claim appears to be altered. Please contact the recipient's county welfare office to validate eligibility. Resubmit the claim with a valid label.
340	This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a Claim Inquiry Form (CIF). The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim.
341	This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a Claim Inquiry Form (CIF). This denied, duplicate procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)
342	Rendering provider required for procedure, none submitted.
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
345	Payment cannot be made for procedures with invalid dates of service.
345A	The PM 160 form sent was not current. Send claim inquiry form with current PM 160 form or document reason for delay in treatment.
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.
347	Authorization previously denied, payment cannot be made.
348	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service already performed on the same day by the same DDS.
348A	The billed procedure cannot be paid because there is an apparent discrepancy between it and procedure D0220 already performed on the same day. If you are requesting re-adjudication for this procedure, submit a Claim Inquiry Form (CIF).
349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.
350	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided for this patient.
351	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided by your office for this patient.
352	The billed service is disallowed because of an apparent discrepancy with a related procedure billed by your office for the same tooth on the same day.
352a	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
353	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
354	The line item is a duplicate of a previous line item on the same claim.
355A	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355B	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355C	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
356	EOMB for different recipient, procedure(s) denied.
357	Procedure deleted/disallowed per provider request.

ARC #	Adjudication Reason Code Description
358	Payment for procedure disallowed per claims review.
359	Payment for procedure disallowed per clinical post-payment review.
360	Sign Notice of Authorization for payment of dated lines.
361	CSL has not been paid; NOA never returned for payment.
362	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
363	Procedure on EOMB is not a benefit of the program.
364	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
365	The maximum allowance for this service/procedure has been paid by Medicare.
366	Dental benefits cannot be paid without proof of payment/denial from Medicare.
367	Medicare payment/denial notice does not have recipient name and/or date of service.
368	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
369	Emergency certification statement is insufficient /not submitted for recipient aid code.
369A	Provider must sign the emergency certification statement.
370	Procedure not a benefit for recipient aid code.
370A	Per box “D” marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
371	Procedure(s) cannot be prior authorized for recipient aid code.
372	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
373	Procedure not payable. CTP benefits terminate at age 19.
374	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.
376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.
377	This procedure is not a benefit for an RDHAP.
377A	Procedure requested is only payable when the patient resides in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF) that is licensed pursuant to Health And Safety Code (H&S Code) Section 1250-1264.
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
380	Fee adjustment, since Other Coverage exists for this claim.
381	Fee adjustment, since Third Party Liability exists for this claim.
382	Fee adjustment, since share of cost exists for this claim.
383	Fee adjustment, since services billed were not provided.
384	Fee adjustment, due to findings of professional peer review.
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).
386A	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.

ARC #	Adjudication Reason Code Description
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).
387A	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
392	Beneficiary is not eligible for CCS/GHPP benefits.
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.
400	EPSDT-supplemental services are not a benefit for patients 21 years and older.
401	The EPSDT supplemental service(s) requested is primarily cosmetic in nature.
402	An alternative service(s) is more cost effective than the requested EPSDT supplemental service(s) and is a benefit of the Medi-Cal dental program.
403	The EPSDT supplemental service(s) requested is not medically necessary.
404	Procedure is disallowed due to presumptive eligibility card not submitted.
405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.
501	Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.
503A	Optional Adult Dental procedure is not a benefit
503B	Optional Adult Dental procedure is not a benefit
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.
555B	Authorization of this line is no longer valid: Treatment was performed as an emergency.
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed.
777	A special exception has been made for this procedure based on the documentation submitted.
888	Line allowed but unpaid due to date of service
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.
	CLINICAL SCREENING CODES
603	Per clinical examination, procedure requested is only allowable under special circumstances.
607A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.
607B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.

ARC #	Adjudication Reason Code Description
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
613A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.
613B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
614A	Per clinical screening, please re-evaluate for: Complete upper denture
614B	Per clinical screening, please re-evaluate for: Complete lower denture
614C	Per clinical screening, please re-evaluate for: Resin base partial denture
614D	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
614E	Per clinical examination, please re-evaluate for: Procedure 706.
614F	Per clinical examination, please re-evaluate for: Procedure 708.
619	Per clinical screening, caries not clinically verified.
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
648	Per clinical screeneing, extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
649A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
662	Per clinical screening, existing prosthesis is adequate at this time.
662A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.

ARC #	Adjudication Reason Code Description
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
667A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.
668	Per clinical screening, the need for procedure is not medically necessary.
668A	Per clinical screening, patient does not wish extractions or any other dental services at this time.
668B	Per clinical screening, patient has selected/wishes to select a different provider.
669A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.
669B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
669C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.
671A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
671B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
671C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
671D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
671E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.
671F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
671G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.
671H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
671I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.
672	Per clinical screening, tooth not present.
672B	Per clinical screening and/or radiographs, tooth number may be incorrect.
673A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
674	Per clinical screening, incomplete treatment plan submitted.
674A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
674C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
680	Per clinical screening, services solely for esthetic purposes are not benefits.
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.

ARC #	Adjudication Reason Code Description
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.
684A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.
684B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.
684C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.
684D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
684E	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Two or more of the above pertain to your case.
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.
685A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
687	Per clinical screening, allowance made for alternate procedure.
692	Per clinical screening, documentation or radiographs, procedure already completed.
693	Per clinical screening, procedure requested is inadequate to correct problem.
693A	Per clinical screening, procedure requested is inadequate to correct problem. Tooth has open, underformed apices. Authorization for root canal will be considered after radiographic evidence of apex closure following apexification.
693B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.
693C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.
694A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.
695	Authorization disallowed as the patient is no longer at the facility.
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.

Claim In Process Reason Codes

The following codes indicate why a claim or TAR is in process in the automated Denti-Cal processing system.

Code	Reason
DV	**DATA VALIDATION** – Document is awaiting review of keyed data against document information.
IR	**INFORMATION REQUIRED** – Document requires more data from the billing provider. An RTD has been sent to the billing provider.
RV	**RECIPIENT VERIFICATION** – Document is awaiting validation of recipient information.
PV	**PROVIDER VERIFICATION** – Document is awaiting validation of provider information.
PR	**PROFESSIONAL REVIEW** – Document is scheduled for professional review.
CS	**CLINICAL SCREENING** – Document is scheduled for a clinical screening review.
SR	**STATE REVIEW** – Document is scheduled for review by Department of Health Care Services.

Accounts Payable/Accounts Receivable Codes

These codes identify the reason for a receivable or payable item shown on an EOB.

Payable Codes

Code	Description
1	Replace Lost Check
2	Penalty Payment (Inactivated)
3	Interim Payment
4	S/URS Adjustment
5	Overpayment of Cash Receipt
9	Prior Underpayment

Receivable Codes

Code	Description
1	S/UR Adjustment
2	Negative Claim Adjustment
3	Interim Payment Adjustment
4	Penalty Adjustment (Inactivated)
5	Overpayment Adjustment
6	Internal Adjustment
9	S/UR Interest

Readjudication Codes

The following codes represent reasons why a claim is being processed for readjudication.

Claim Correction Codes

Code	Reason
01	Paid wrong provider number
02	Rendering provider license number missing
20	Corrected tooth number or arch code
21	Retroactive eligibility granted
22	Quantity of service provided or corrected
23	Corrected procedure code/fee
25	Corrected date of service
26	Corrected Medicare crossover amount
27	Share-of-Cost/Other coverage amount provided or corrected
29	Corrected place of service
30	New or additional documentation submitted
39	Denial upheld - See related adjudication/policy code
50	Fair hearing decision
51	Readjudication based on medical appeal
52	Readjudication based on mental appeal
53	Readjudication based on employment appeal
60	Readjudication based upon CDA peer review decision
61	Per post-payment screening, service below standard
62	Per post-payment screening or quality review, service not performed
63	Readjudication based upon professional re-evaluation
64	Readjudication of original underpayment based on Delta Quality Control (QC) review
65	Readjudication of original overpayment based on Delta Quality Control (QC) review
66	Original payment incorrect due to processing error - Erroneous Payment Correction (EPC) system
70	CRT input error
71	Provider claim preparation error
72	Claim not received within six months from last date of service
73	Overpayment
74	CIF not submitted for reconsideration within 60 days of the EOB date
75	First level appeal not submitted within 90 days of the EOB date
90	Death transaction reversal
95	Original payment of claim adjusted per S/UR
96	Readjudication of orig payment based on Delta review
99	Special message

Resubmission Turnaround Document (RTD) Codes and Messages

The following codes represent missing or incorrect information originally submitted on TAR/Claim forms.

Beneficiary RTD Codes

Code	Reason
01	Submit x-rays with EDI label
02	Submit beneficiary's CIN/BIC ID
03	Verify birth date: month/day/year
04	EOMB or proof of denial/ineligibility
05	Verify recipient sex
06	Submit documentation with EDI label
07	Verify beneficiary's CIN/BIC ID
08	CIN belongs to someone else, send copy of BIC card
09	Verify patient name
10	Send photo ID by DMV/credible ID
11	Submit beneficiary facility name/address/phone#.

Provider RTD Codes

Code	Reason
13	Ortho - continuation signature reqd
16	Submit rendering provider number
18	Verify provider name and number
19	Verify billing agent name/number

X-Ray RTD Codes

Code	Reason
30	Submit current xrays/photos for all restorative tx
31	Submit current x-rays/photos
32	Send x-ray showing apices of tooth
33	Send PAs of all involved areas
34	Send x-rays of remaining teeth
35	Send final root canal x-rays
36	Procedure and description mismatch
37	Procedure tooth/surface mismatch
38	Submit opposing arch treatment plan
39	Submit x-rays of opposing arch
40	Submit BWs and periapical films
41	Submit x-rays/documentation
43	Send PA of present tooth condition

Clerical RTD Codes

Code	Reason
42	Submit completed HLD Index form
46	Indicate date of service
47	Indicate procedure code
48	Indicate tooth surface
49	Indicate upper/lower arch
50	Submit type of partial, i.e., procedure number
51	Procedure requires tooth code
52	Signature missing or invalid. Sign RTD.
54	Submit date of enrollment in HF
55	Indicate quadrant/area for treatment
56	Need other cov EOB/RA or denial
57	Submit other coverage fee schedule.
58	DOS cannot be after receipt date
59	Submit missing fees
60	POS code missing or invalid
61	Order date after NOA receipt date
62	Tooth number missing or invalid
63	Send copy of surgeon's claim/TAR
64	Submit your usual and customary fee
66	Submit 3 digit procedure code
67	Incomplete DC054 form was submitted
68	List teeth to be replaced & clasped
69	Submit all NOA pages/dates of service

Consultant RTD Codes

Code	Reason
70	Submit completed DC054 form
71	Procedure requires documentation
72	Must document lost/damaged dentures
73	Indicate quadrants for surgery
74	Note repair; send lab bill, if applicable
75	Submit Periodontal Evaluation Form
76	Submit copy of Operative Report
77	DOS needed for completed treatment
78	O.R. report required
79	Submit EOB from primary surgeon

Maxillofacial Program RTD Codes

Code	Reason
81	Submit history/diagnosis/symptom
82	Submit narrative report
83	Cleft lip/palate or facial anomaly?
84	Submit anesthesiologist report
85	Submit diagnostic study models
86	Submit pre-treatment panorex X-ray
87	Submit in-treatment panorex X-ray
88	Submit post-treatment panorex
89	Submit cephalometric X-ray
90	Submit intraoral photograph/slide
91	Send post-ortho diagnostic material
92	Submit TMJ X-ray
93	Submit copy of occlusal analysis
94	Send model/photo/film; note need
95	Submit documentation
96	Use MFO/cleft palate codes in SMA
97	Submit invoice for H.A. or appliance
98	Submit copy of CCS approval
99	Other (unspecified above)

TAR/Claim Policy Codes and Messages

These codes represent reasons that an entire document is being denied. The use of these codes causes all lines of the document to be denied.

Code	Reason
01	Duplicate claims/TARs from same/ different providers cannot be processed.
02	Payment disallowed – exceeds six month billing limit.
03	NOA cannot be paid; TAR has expired.
04	Cannot process total claim; eligibility not established.
05	Payment disallowed – exceeds 12 month billing limit.
06	Cannot adjust claim received 13 mos or more after adjudication date.
07	Primary carrier paid more than this program allows.
08	POE label is invalid for dental program; contact county office.
09	Pt in Managed Care Program (MCP/PHP/GMC/HMO/DMC) which includes dental benefits.

Code	Reason
10	TAR/Claim cannot be processed; no services were entered.
11	TAR/Clm/NOA cannot be processed without valid provider signature.
12	Unknown procedure codes, document unprocessable.
13	Recipient benefits do not include dental services.
15	Authorized services cannot be transferred between providers; claim denied.
16	Beneficiary not eligible for Medi-Cal; may have benefits through Healthy Families.
17	Procedure service data not submitted; please resubmit.
18	Recipient data not submitted; cannot process TAR/Claim.
19	Authd serv cannot be transferred between recipients; claim denied.
20	Second reeval or reevaluation of expired TAR not granted. Submit new TAR.
21	RTD was unsigned and cannot be used to correct claim errors.
22	Billing provider ID not on file; must be enrolled.
23	Out-of-state providers need prior authorization for non-emerg serv.
24	Out-of-country serv cov only for emerg hospit auth by field office.
25	Recipient eligibility not established for the dates of service.
26	Patient information on TAR/claim does not match State eligibility file.
27	Provider requested document be deleted.
28	Prov name does not match Delta file; no payment/authorization.
29	Recipient not on State eligibility file; payment denied.
30	Billing provider and recipient not on file, TAR/claim denied.
31	Recipient data insufficient to process claim or TAR after RTD.
32	Billing provider not enrolled for dates of svc, TAR/claim denied.
33	Mixture of 3, 4 & 5 digit procedure codes not allowed.
34	X-rays appear to be of another person – payment disallowed.

Code	Reason
35	Payment of inpatient services contingent on submission of an O.R. rpt.
36	Auth disallowed, patient did not appear for a clinical screening.
37	Claims/TARs must be submitted in the English language.
38	Payment disallowed – procedure(s) are non-benefits for HMPP #155.
39	CMSP Code not eligible under Denti-Cal prior 01/01/90. Send to County.
40	Procedures not a benefit for recipient aid code.
41	Pregnancy or emergency documentation is insufficient/not submitted for aid code.
42	Prior authorization not allowed for emergency services or pregnancy aid code.
43	Payment for claim disallowed per S/UR.
44	No EOB/RA, fee schedule, usual & customary fee, or proof of denial submitted.
45	CTP benefits terminate at age 19.
46	Provider not enrolled as certified Orthodontist.
47	Certified Orthodontist not associated to this service office.
48	Procedures allowable under special circumstances only
49	Payment cannot be made; our records indicate the patient is deceased.
50	Denied due to invalid response to RTD.
51	Document denied due to expired PM 160.
52	Share of cost unmet; not eligible.
53	Patient cancelled scheduled clinical evaluation. Please contact patient.
54	Service(s) granted by Fair Hearing process; please contact patient.
55	Pymt cannot be approved when new Issue Date/BIC ID are not provided or valid.
56	TARs not allowed for univ project; send new TAR with G prov billing number.
57	Authorization disallowed as the patient is no longer at the facility.
58	Emergency services documentation is insufficient. Bene cap applied.
59	Bene cap not applied. Documentation of services qualifies as an emergency.
60	Bill prov has discontinued practicing at this office location for these DOS.

Code	Reason
61	Use of beneficiary's SSN is no longer acceptable.
69	Payment calculation based on date of service.
70	For CMSP dental services after 09/30/05 contact Doral Dental (1-800-341-8478).
71	Payment denied. Time limitation for submitting CMSP claims has expired.

Claim Inquiry Response (CIR) Status Codes and Messages/Claim Inquiry Form (CIF) Action Codes and Messages

The CIR form is a computer-generated response to a provider's CIF. In addition to provider and patient information, the response will appear as a status code and explanation to the CIF, as follows:

1A Provider indicated wrong DCN on CIF

1B Previous history needs to be updated

1C Provider indicated multiple DCNs on one CIF

1D Check problems needed CIF to correct

1E Delta Input Prep error

1F Other miscellaneous errors

5A Forwarded to on-site queue

5B Secondary review

5C Waiting for State directive

5D Incomplete application – letter sent

5E Request for additional information – 35 day letter sent

5F Denied applications

5G Returned call

6A Use of beneficiary's SSN is no longer acceptable

01 Claim never received; please submit new claim

02 Claim in process; awaiting final adjudication

03 RTD has been sent, please respond on original RTD

04 Claim under professional review

05 Claim processed EOB_____ DT_____ $_____

08 Insufficient documentation; procedure disallowed

09 Requires prior authorization

11 Claim not recvd within 6 mos from last mo of service

12 Claim has been readjudicated for payment

13 Submit original NOA for re-evaluation

14 TAR never received; please submit new TAR

15 TAR in process; awaiting adjudication

18 Notice of Authorization (NOA) has been processed

19 NOA expired submit new TAR

20 Procedure not a benefit of program

21 Procedure previously paid to same or other office

22 Procedure is adjunctive to another procedure

23 NOA has been readjudicated

24 Procedures not performed within 120-day time limitation

26 Lack of beneficiary eligibility, claim disallowed

27 Other coverage payment exceeds SMA

28 Denial upheld

29 Denial – recipient benefits do not include dental

30 Procedures not allowed based on professional review

31 Incomplete treatment plan submitted; denial upheld

32 Exceeded 6 month time limitation; denial upheld

33 Per documentation; claim in process

34 Per our records, X-rays returned at time of processing

35 Signature missing, adjustment/ correction cannot be made

36 Open – no description

37 Acknowledged electronic funds transfer complaint

38 Please complete Claim Inquiry Form for each claim

86 Payment adjusted per Surveillance and Utilization Review (S/UR).

93 Original claim overpayment adjusted due to Quality Control (QC) review.

94 Original claim underpayment adjusted due to Quality Control (QC) review.

95 Original payment incorrect - adjusted by Erroneous Payment Correction (EPC) system.

Prepaid Health Plans (PHP) and Codes

Denti-Cal beneficiaries who are enrolled in prepaid health plans may be eligible for either comprehensive or non-comprehensive benefits. A beneficiary enrolled in a comprehensive prepaid health plan is entitled to both medical and dental benefits as defined by the plan. Services must be performed by a provider enrolled in the prepaid health plan. Emergency services only may be billed to the prepaid health plan. With a non-comprehensive plan, the beneficiary has medical benefits only and is eligible for dental benefits through the Denti-Cal program.

Following is a list of current prepaid health plan codes:

Code	Plan Name
403	Care 1st Health Plan
405	Health Net of California, Inc.
406	Safe Guard Health Plan (Los Angeles)
409	Access Dental Plan (Los Angeles)
410	American Health Group (Los Angeles)
413	Western Dental Services (Los Angeles)
414	Western Dental (Riverside)
415	Western Dental (San Bernardino)
416	Liberty Dental Plan of Calif, Inc. (Los Angeles)
417	Community Dental Services, Inc. (Los Angeles)
421	Access Dental (Sacramento)
424	Western Dental (Sacramento)
425	Liberty Dental Plan of California, Inc. (Sacramento)
426	Community Dental Services (Sacramento)

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Section 8 - Fraud, Abuse and Quality of Care

Surveillance and Utilization Review Subsystem (S/URS)

Introduction

Denti-Cal's Surveillance and Utilization Review (S/UR) department monitors for suspected fraud, abuse and poor quality of care as part of its duties as the Fiscal Intermediary for the Department and California Medi-Cal Dental Program. In overseeing appropriate utilization in the program, the S/UR department helps Denti-Cal meet its ongoing commitment to improving the quality of dental care for Medi-Cal beneficiaries.

The goal of the S/UR department is to ensure providers and beneficiaries are in compliance with the criteria and regulations of the Denti-Cal program.

Under the authority of the Federal Medicaid statutes, California Welfare and Institutions Code (W & I), the, Business & Professions Code, Dental Practice Act (see Web site http://www.dbc.ca.gov/lawsregs/), and the California Code of Regulations (CCR) Title 22, and with the assistance of the California Dental Association's Guidelines for the Assessment of Clinical Quality of Professional Performance, the S/UR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. The S/UR department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard and/or unnecessary treatment.

Methods of Evaluation

The S/UR department employs several different means to evaluate suspected fraud and abuse of the Denti-Cal program, including:

- **Utilization Review Analysis**: This statistical analysis compares a provider activity with that of his or her peers within a certain range, such as geographic area or dental specialty.
- **Referrals**: The Department of Health Care Services (DHCS), Medi-Cal Dental Services Division (MDSD), works in collaboration with the Department of Justice, the Bureau of Medi-Cal Fraud & Elder Abuse and the Dental Board of California on cases of suspected fraud, abuse and poor quality of care. These agencies often refer provider names for investigation to the S/UR department. The S/UR department also receives referrals from internal sources such as Professional Review Denti-Cal dental consultants.
- **Clinical Screening Examinations**: Patients are selected by the S/UR department for examination by a Denti-Cal clinical screening consultant to determine if certain procedures for which authorization is requested are medically necessary, verify if billed procedures were in fact provided, and evaluate the professional quality of the treatment that was provided.
- **Beneficiary Fraud Unit**: A part of the S/UR department, the Beneficiary Fraud unit, monitors conflicts in patient dental histories to determine if Medi-Cal identification cards are being misused or services are being billed improperly.
- **S/URS Audits**: When poor quality of care, abuse, over utilization, or fraud is suspected, the S/UR department may elect to conduct an audit of patient records, including radiographs, obtained from the provider's office to gather additional information about the provider's activity.

Possible S/URS Actions

The S/UR department will take appropriate action at the direction of the Department of Health Care Services, MDSD, to address situations where poor quality of care, inappropriate billings, and/or inappropriate utilization of services are identified. Such actions may include one or more of the following:

- **Summary of Findings Letter**: When minor non-conformities to Denti-Cal criteria are detected, the S/UR department will send a letter informing and educating the provider of Denti-Cal criteria, including program limitations, exclusions, and special documentation requirements. The letter will also direct the provider to modify his or her performance in accordance with the criteria and standards of the Denti-Cal program.
- **Corrective Action Letter**: When poor quality of care is identified, Denti-Cal will send a letter to the provider requesting that he or she take immediate action to correct the problem within 60 days. The letter will inform the provider that if the correction is not made within 60 days, Denti-Cal will take action to recover payment for the procedures in question.
- **Prior Authorization/Special Claims Review**: The Department may require providers to obtain prior authorization for certain Denti-Cal procedures to protect beneficiaries from unnecessary treatment. The prior authorization procedure is described in "Section 2: Program Overview" of this Handbook. Denti-Cal may place a provider on prior-authorization review for non-emergency procedures at any time, either on a random basis or with cause. If prior authorization review is initiated, there are no appeal rights.

  If the S/UR department determines that a provider is billing Denti-Cal by submitting improper claims, including claims which incorrectly identify or code services provided, or are for procedures that are of poor quality, or were not provided, the provider may be placed on Special Claims Review. The provider will then be required to submit pre-operative and/or post-operative radiographs and other documentation to demonstrate the quality of treatment provided and to verify that the procedure provided corresponds to the procedure billed. Utilization control requirements are in addition to the requirements outlined in "Section 2: Program Overview" of this Handbook and may be imposed under the authority of Title 22, California Code of Regulations (CCR), Sections 51159, 51455, and 51460. If Special Claims Review is initiated, there are no appeal rights.
- **Recovery of Payment**: Recovery for paid procedures may be obtained by withholding the amount to be reimbursed from a provider's future Denti-Cal payments. Recovery may occur when a post-operative clinical screening exam or post payment review identifies any discrepancies in the billing or delivery of those services and/or for failure to complete a noticed corrective action. Recovery may be imposed retroactively for a period up to three (3) years from the date that the procedures were performed.
- **Removal From Referral List**: If a provider's performance is deemed below the standard of professional care for a particular course of treatment, the provider may be subject to removal from the Denti-Cal provider referral list.
- **Other Agency Referral**: When S/URS investigations disclose a situation that may require criminal prosecution or action beyond the jurisdiction of Denti-Cal, the matter will be referred to the Department of Health Care Services, MDSD, for possible referral to the Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse and/or the Dental Board of California. Referrals to these agencies may result in further investigation, prosecution, and

suspension of the provider's license to practice.

- **Suspension from Denti-Cal**: Non-compliance with corrective action and/or continued and persistent substandard care, fraud, and/or abuse as well as violation of any Medi-Cal statute, rule or regulation relating to the provision of health care services under the California Medical Assistance Program can lead to suspension of a provider's participation in the Denti-Cal program.

Help Stop Fraud

Providers can help stop fraud and abuse in the Denti-Cal program. If providers or members of the provider's staff are aware of any suspicious or fraudulent activity, send information to:

Denti-Cal
Surveillance & Utilization Review
Department
PO Box 13898
Sacramento, CA 95853-4898

Please include the name of the person reporting the incident, the phone number, the provider's name, the location of his/her office, and an explanation of the incident. **Anonymity will be maintained upon request**. Because of the confidential nature of investigations, individuals will not be notified of the outcome of any case. All referrals are appreciated and will contribute significantly to the ongoing efforts of detecting, halting and preventing fraud and abuse in the Denti-Cal program.

Statutes and Regulations

Pertaining to Providers

This section details certain State statutes and regulations that are binding on Denti-Cal providers, their designated agents, all public and private agencies and/or individuals that are engaged in planning, providing, or securing Denti-Cal services for or on the behalf of recipients or applicants.

Confidentiality

The W & I Code, Section 10850 provides that names, addresses, and all other information concerning circumstances of any applicant or recipient of Denti-Cal services for whom, or about whom, information is obtained shall be considered confidential and shall be safeguarded. Both the release and possession of confidential information in violation of this statute are misdemeanors.

Record Keeping Criteria

Through its audit process, the S/UR department has found many areas to be deficient in the documentation of treatment for Medi-Cal dental beneficiaries. Lack of proper documentation may result in an unfavorable audit and potential recovery of payments. It is also important to note that all documentation on Treatment Authorization Requests (TARs) and claims must be consistent with and supported by documentation in the record of treatment.

Providers should carefully review the full text of regulations regarding the keeping and availability of records.

Title 22, California Code of Regulations (CCR), Section 51476. (a) states:

> Each provider shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary. Required records shall be made at or near the time at which the service is rendered. Such records shall include, but not be limited to the following:
>
> (1.) Billings.
> (2.) Treatment authorization requests.
> (3.) All medical records, service reports, and orders prescribing treatment plans.
> (4.) Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries.
> (5.) Copies of original purchase invoices for medication, appliances, assistive devices, written requests for laboratory testing and all reports of test results, and drugs ordered for or supplied to beneficiaries.
> (6.) Copies of all remittance advices which accompany reimbursement to providers for services or supplies provided to beneficiaries.

(7.) Identification of the person rendering services. Records of each service rendered by nonphysician medical practitioners (as defined in California Code of Regulations (CCR), Title 22, Section 51170) shall include the signature of the nonphysician medical practitioner and the countersignature of the supervising physician.

Title 22, California Code of Regulations (CCR), Section 51476. (d) states:

Every practitioner who issues prescriptions for Medi-Cal beneficiaries shall maintain, as part of the patient's chart, records which contain the following for each prescription:

(1.) Name of the patient.
(2.) Date prescribed.
(3.) Name, strength and quantity of the item prescribed.
(4.) Directions for use.

Title 22, California Code of Regulations (CCR), Section 51476. (g) states:

A provider shall make available, during regular business hours, all pertinent financial books and all records concerning the provision of health care services to a Medi-Cal beneficiary, and all records required to be made and retained by this section, to any duly authorized representative of the Department acting in the scope and course of employment including, but not limited to, employees of the Attorney General, Medi-Cal Fraud Unit duly authorized and acting within the scope and course of their employment. Failure to produce records may result in sanctions, audit adjustments, or recovery of overpayments, in accordance with California Code of Regulations (CCR), Title 22, Section 51458.1.

Welfare & Institutions Code, Section 14124.1. states:

Each provider, as defined in Section 14043.1, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall keep and maintain records of each such service rendered, the beneficiary or person to whom rendered, the date the service was rendered, and such additional information as the department may by regulation require. Records herein required to be kept and maintained shall be retained by the provider for a period of three years from the date the service was rendered.

NOTE: Examples of appropriate documentation to be placed in the services rendered portion of the patient chart include, but are not limited to:

- Type and dosage of local anesthetic;
- Type and dosage of vasoconstrictor;
- Number of carpules used;
- When local anesthetic is not used for procedures which normally call for local anesthetic, but is not used;
- Original radiographs and photographs must be included;
- Specific treatment and materials placed for restorative services;
- Specific service provided for topical fluoride application;
- Written documentation explaining emergency services;
- The extent and complexity of a surgical extraction; and
- Specific documentation for medical necessity, observations and clinical findings, the specific treatment rendered and medications or drugs used during periodontal procedures.

Identification in Patient Record

Denti-Cal will not pay for services unless the rendering provider is actively enrolled in the Denti-Cal program at the time of treatment. Treatment of Denti-Cal patients by un-enrolled providers is not covered and will be subject to recovery of payments made.

Business and Professions Code, Section 1683. states:

(a.) Every dentist, dental health professional, or other licensed health professional who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name, or an identification number and initials, next to the service performed and shall date those treatment entries in the record. Any person licensed under this chapter who owns, operates, or manages a dental office shall ensure compliance with this requirement.

(b.) Repeated violations of this section constitute unprofessional conduct.

NOTE: Billing providers MUST ensure that all their rendering providers are enrolled in the DentiCal program prior to treating Medi-Cal patients. Payments made to billing providers for services performed by unenrolled rendering providers are not covered and will be subject to recovery.

Cause for Recovery

Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Overpayments may be recovered when the department discovers information that indicates the provider may have engaged in practices that have resulted in over reimbursement.

Welfare and Institutions Code Title 22, Section 51458.1. states:

(a.) The Department shall recover overpayments to providers including, but no t limited to, payments determined to be:

(1.) In excess of program payment ceilings or allowable costs.

(2.) In excess of the amounts usually charged by a provider.

(3.) For services not documented in the provider's records, or for services where the provider's documentation justifies only a lower level of payment.

(4.) Based upon false or incorrect claims or cost reports from providers.

(5.) For services deemed to have been excessive, medically unnecessary or inappropriate.

(6.) For services prescribed, ordered or rendered by persons who did not meet the standards for participation in the Medi-Cal program at the time the services were prescribed, ordered or rendered.

(7.) For services not covered by the program.

(8.) For services to persons not eligible for program coverage when the services were provided.

(9.) For Medi-Cal covered services already paid for by the beneficiary, but not yet refunded, or for services already reimbursed by the Department or other coverage.

(10.) For services that should have been billed to other coverage.

(11.) For services not ordered or prescribed, when an order or prescription is required.

(12.) For services not authorized, when a treatment authorization request is required.

(13.) In violation of any other Medi-Cal regulation where overpayment has occurred.

(14.) The provisions of Sections 51488. and 51488.1. shall prevail in circumstances that conflict with this section.

Special Permits

Providers who administer general anesthesia and/or intravenous conscious sedation/ analgesia shall have valid anesthesia permits with the California Dental Board. Provision of these services is not a benefit of the program when provided by persons not holding the appropriate permit and payment is subject to recovery.

Utilization of Nurse Anesthetist

Providers who utilize the services of Nurse Anesthetists in a dental office must also hold the appropriate permit.

Business and Professions Code, Section 2827. states:

> The utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist.
>
> If a general anesthetic agent is administered in a dental office, the dentist shall hold a permit authorized by Section 1646.

General Anesthesia (D9220 and D9221)

General anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

Business and Professions Code, Section 1646.1. states:

(a.) No dentist shall administer or order the administration of general anesthesia on an outpatient basis for dental patients unless the dentist either possesses a current license in good standing to practice dentistry in this state and holds a valid general anesthesia permit issued by the board or possesses a current permit under Section 1638 or 1640 and holds a valid general anesthesia permit issued by the board.

(b.) No dentist shall order the administration of general anesthesia unless the dentist is physically within the dental office at the time of the administration.

(c.) A general anesthesia permit shall expire on the date provided in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(d.) This article does not apply to the administration of local anesthesia or to conscious-patient sedation.

Business and Professions Code, Section 1646.7. states:

(a.) A violation of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation.

(b.) A violation of any provision of this article or Section 1682 is grounds for suspension or revocation of the physician's and surgeon's permit issued pursuant to this article by the Dental Board of California. The exclusive enforcement authority against a physician and surgeon by the Dental Board of California shall be to suspend or revoke the permit issued pursuant to this article. The Dental Board of California shall refer a violation of this article by a physician and surgeon to the Medical Board of California for its consideration as unprofessional conduct and further action, if deemed necessary by the Medical Board of California, pursuant to Chapter 5 (commencing with Section 2000). A suspension or revocation of a physician and surgeon's permit by the Dental Board of California pursuant to this article shall not constitute a disciplinary proceeding or action for any purpose except to permit the initiation of an investigation or disciplinary action by the Medical Board of California as authorized by Section 2220.5.

(c.) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Dental Board of California shall have all the powers granted therein.

Intravenous Conscious Sedation/Analgesia (Conscious Sedation) (D9241 and D9242)

Intravenous conscious sedation/analgesia (Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes and the ability to respond appropriately to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

"Intravenous Conscious Sedation/Analgesia" (Conscious Sedation) does not include the administration of oral medications or the administration of a mixture of nitrous oxide and oxygen, whether administered alone or in combination with each other.

Business and Professions Code, Section 1647.2. states:

(a.) No dentist shall administer or order the administration of, conscious sedation on an outpatient basis for dental patients unless one of the following conditions is met:
  (1.) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.
  (2.) The dentist possesses a current permit under Section 1638 or 1640 and either holds a valid anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.

(b.) A conscious sedation permit shall expire on the date specified in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(c.) This article shall not apply to the administration of local anesthesia or to general anesthesia.

(d.) A dentist who orders the administration of conscious sedation shall be physically present in the treatment facility while the patient is sedated.

Business and Professions Code, Section 1647.9. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

Non-intravenous Conscious Sedation (Oral Conscious Sedation) (D9248)

Non-intravenous conscious sedation (Oral Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes and the ability to respond appropriately to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) orally, by patch and by intramuscular or subcutaneous injection with appropriate monitoring.

The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation.

For very young or handicapped individuals, incapable of the usually expected verbal response, a minimally depressed level of consciousness should be maintained.

"Minor patient" means a dental patient under the age of 13 years.

"Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name, and the location where

the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.

Business and Professions Code, Section 1647.11. states:

(a.) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to a minor patient unless one of the following conditions is met:

(1.) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, conscious sedation permit, or has been certified by the board, pursuant to Section 1647.12, to administer oral sedation to minor patients.

(2.) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to minor patients in compliance with, and pursuant to, this article.

(b.) Certification as a provider of oral conscious sedation to minor patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c.) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

Business and Professions Code, Section 1647.14. states:

(a.) A physical evaluation and medical history shall be taken before the administration of, oral conscious sedation to a minor. Any dentist who administers, or orders the administration of, oral conscious sedation to a minor shall maintain records of the physical evaluation, medical history, and oral conscious sedation procedures used as required by the board regulations.

(b.) A dentist who administers, or who orders the administration of, oral conscious sedation for a minor patient shall be physically present in the treatment facility while the patient is sedated and shall be present until discharge of the patient from the facility.

(c.) The drugs and techniques used in oral conscious sedation to minors shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.

Business and Professions Code, Section 1647.17. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, certificate, license, or all three, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

Oral Conscious Sedation for Adult Use

As used in this article, the following terms have the following meanings:

(d.) Adult patient" means a dental patient 13 years of age or older.

(e.) Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name and the location at which the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.

(f.) Oral conscious sedation" means a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and

continuously an airway, and respond appropriately to physical stimulation or verbal command. "Oral conscious sedation" does not include dosages less than or equal to the single maximum recommended dose that can be prescribed for home use.

(1.) The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation.

(2.) For the handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

Business and Professions Code, Section 1647.19. states:

(a.) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to an adult patient unless the dentist possesses a current license in good standing to practice dentistry in California, and one of the following conditions is met:

(1.) The dentist holds a valid general anesthesia permit, holds a conscious sedation permit, has been certified by the board, pursuant to Section 1647.20, to administer oral sedation to adult patients, or has been certified by the board, pursuant to Section 1647.12, to administer oral conscious sedation to minor patients.

(2.) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to adult patients in compliance with, and pursuant to, this article.

(b.) Certification as a provider of oral conscious sedation to adult patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c.) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen, or to the administration, dispensing, or prescription of postoperative medications.

Billing Denti-Cal

Billing for Benefits Provided

Title 22, California Code of Regulations (CCR), Section 51470. (a) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal benefits not provided to a Medi-Cal beneficiary.

Title 22, California Code of Regulations (CCR), Section 51470. (d) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal covered benefits provided to a Medi-Cal beneficiary:

(1.) For which the provider has received and retained payment.

(2.) Which do not meet the requirements of Department regulations.

Sub-Standard Services

Title 22, California Code of Regulations (CCR), Section 51472. states:

No provider shall render to a Medi-Cal beneficiary health care services which are below or less than the standard of acceptable quality.

Excessive Services

Title 22, California Code of Regulations (CCR), Section 51473. states:

No provider shall render to any Medi-Cal beneficiary, or submit a claim for reimbursement for, any health care service or services clearly in excess of accepted standards of practice.

Business and Professions Code, Section 1685. states:

In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for a person licensed under this chapter to require, either directly or through an office policy, or knowingly permit the delivery of dental care that discourages necessary treatment or permits clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment, as determined by the standard of practice in the community.

Prohibition of Rebate, Refund, or Discount

Title 22, California Code of Regulations (CCR), Section 51478. states:

> No provider shall offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal beneficiary. No provider shall solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal beneficiary.

Billing for Suspended Provider

Title 22, California Code of Regulations (CCR), Section 51484. states:

> No provider shall bill or submit a claim for or on behalf of any provider who has been suspended from participation in the California Medical Assistance Program, for any services rendered in whole or in part by any such suspended provider during the term of such suspension.

Submission of False Information

Title 22, California Code of Regulations (CCR), Section 51485. states:

> No provider shall submit or cause to be submitted any false or misleading statement of material fact when complying with departmental regulations, or in connection with any claim for reimbursement, or any request for authorization of services.

Overpayment Recovery

The Denti-Cal program collects overpayments identified through an audit or examination, or any portion thereof from any provider. A provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170). Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings if the findings are against the provider. Overpayments will be returned to a provider with interest if findings are in favor of the provider.

Title 22, California Code of Regulations (CCR), Section 51470. states:

(a.) When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such

overpayment. The overpayment shall be recovered by any of the following methods:

(1.) Lump sum payment by the provider.

(2.) Offset against current payments due to the provider.

(3.) A repayment agreement executed between the provider and the Department.

(4.) Any other method of recovery available to and deemed appropriate by the Director.

(b.) An offset against current payments shall continue until one of the following occurs:

(1.) The overpayment is recovered.

(2.) The Department enters into an agreement with the provider for repayment of overpayment.

(3.) The Department determines, as a result of proceedings under this article, that there is no overpayment.

(c.) The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).

(d.) Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.

(e.) Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest computed at the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f.) (As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

Civil Money Penalties

Title 22, California Code of Regulations (CCR), Section 51485.1 states:

(a.) The Director may assess civil money penalties against a person or provider ("provider") pursuant to Welfare and Institutions Code Section 14123.2 after a determination that the provider knows or has reason to know that items or services:

(1.) Were not provided as claimed,

(2.) Are not reimbursable under the Medi-Cal Program as provided in subsection (d), or

(3.) Were claimed in violation of an agreement with the State.

(b.) The Director's determination of whether a provider "knows or has reason to know" that items or services were not provided, are not reimbursable, or were claimed in violation of an agreement with the State (hereafter "improperly claimed"), shall be based on the following standards:

(1.) Knows: The provider is aware of a high probability of the existence of the fact that items or services were improperly claimed, or

(2.) Has reason to know: The provider has information from which a reasonable person in that position would infer that items or services were improperly claimed.

(c.) The Director's determination of whether the provider knows or has reason to know that items or services were "not provided as claimed" shall be based on information available pursuant to Section 51476.

(d.) The Director shall determine whether or not the provider knows or has reason to know that claimed items or services are "not reimbursable under the Med-Cal Program" in the following instances:

(1.) The provider has been suspended from participation in the Program,
(2.) The claimed items or services are substantially in excess of patient needs as de fined in Section 51303(a),
(3.) The items or services are deficient in quality compared with professionally re cognized standards of health care (See Section 51472),
(4.) The provider has demonstrated a pattern of abusive overbilling to the Medi-Cal Program. Evidence of such overbilling shall include, but not be limited to:
(A.) Dentical audit adjustments repeated in two or more fiscal years except if there is a pending appeal where these adjustments are still at issue,
(B.) Repeated submission of improperly coded or identified claims. Evidence of such overbilling shall not include repeated submission of claims which have been denied payment previously, even though such payment denial was not contested.

(e.) The Director's determination of whether the provider knows or has reason to know that items or services were "claimed in violation of an agreement with the State" shall be based on the terms of the written agreement, and on other relevant evidence as that term is defined in Section 51037(e)(1). The Director shall consider only material violations which go to the merits of the agreement as distinguished from those which affect only form.

(f.) A civil money penalty shall be no more than three times the amount claimed by the provider for each item or service. It shall be within the Director's discretion to assess a lower penalty. In setting the amount of the penalty, the Director may consider evidence of mitigating circumstances submitted by the provider. Examples of such evidence include, but are not limited to:
(1.) Clerical error.
(2.) Good faith mistake.
(3.) Reliance on official publications.
(4.) Prior record of properly submitted claims.

(g.) An assessment of civil money penalties shall be effective upon the 60th calendar day after the date that the Department serves notice to the provider of the determination. Such notice shall be in writing, and shall include grounds for the determination.

(h.) A provider shall have the right to appeal the determination by filing a request for hearing pursuant to Section 51022. The effective date of the assessment shall be deferred until this request is rejected or a final administrative decision is adopted.

(i.) Upon the effective date of assessment, the Director shall collect the civil money penalty in accordance with the procedures set forth in Sections 14115.5 and 14172 of the Welfare and Institutions Code and Section 51047.

(j.) Interest shall accrue on any unpaid balance of a civil money penalty from the effective date of assessment, at the rate specified in Section 14172(a) of the Welfare and Institutions Code.

(k.) Civil money penalty appeal hearings shall be conducted pursuant to the procedural guidelines set forth in Section 51016 et seq. (Title 22, CAC, Article 1.5).

(l.) Assessment of civil money penalties pursuant to Welfare and Institutions Code Section 14123.2 shall not operate to bar imposition of any other applicable penalty provisions, such as those contained in Welfare and Institutions Code Section 14171.5.

Utilization Controls

Title 22, California Code of Regulations (CCR), Section 51159 states:

Utilization controls that may be applied to services set forth in this chapter include:

(a.) Prior authorization, which is approval in advance of the rendering of service of the medical necessity and program coverage of the requested services, by a Department of Health consultant or PCCM plan. In determining what services shall be subject to prior authorization, the Director shall consider factors which include, but are not limited to:
  (1.) Whether the services to be controlled are generally considered to be elective procedures.
  (2.) Whether other physician procedures not subject to prior authorization are sufficient in scope and number to afford beneficiaries reasonable access to necessary health care services.
  (3.) The level of program payment for procedures.
  (4.) The cost effectiveness of applying prior authorization as a utilization control.

(b.) Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

(c.) Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

(d.) Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

Prior Authorization

Title 22, California Code of Regulations (CCR), Section 51455 states:

(a.) Any provider may be subjected to a requirement of prior authorization for all or certain specified services to be rendered under the California Medical Assistance Program, by written notice served on such provider from the Director or a carrier. The requirement for prior authorization may be imposed on such provider by the Director upon a determination that the provider has been rendering unnecessary services to a Medi-Cal beneficiary.

(b.) As used in this regulation, "unnecessary services" includes but is not limited to any of the following which exceed customary and usual practices in terms of frequency, quantity, propriety, or length of treatment:
  (1.) Office, home or inpatient visits.
  (2.) Furnishing, prescribing or ordering drugs, appliances, services, hospital, skilled nursing facility or intermediate care facility admissions.

(c.) The written notice of requirement for prior authorization shall state the nature, type, and extent of the services determined by the director to have been unnecessary, and shall also state which services shall be subject to prior authorization and the duration that such prior authorization shall remain in force."

Special Claims Review

Title 22, California Code of Regulations (CCR), Section 51460 states:

(a.) The Department may place any provider on special claims review for specific or all services provided. The special claims review may be performed by the Department, or by the fiscal intermediary under direction of the Department. Special claims review may be imposed on a provider upon a determination that the provider has submitted improper claims, including claims

which incorrectly identify or code services provided.

(b.) A provider, while on special claims review, shall furnish any material requested by the Department in order to substantiate specific or all claims subject to special claims review.

(c.) The Department shall provide written notice to any provider placed on special claims review. The written notice shall include the following:

(1.) Services determined to have been improperly billed by the provider.

(2.) Services subject to special claims review.

(3.) Documentation to be submitted with all claims subject to special claims review.

(4.) Instructions for submission of claims subject to special claims review."

Administrative Hearings

Provider Audit Hearing

Title 22, California Code of Regulations (CCR), Section 51017 states:

A provider may request a hearing under the provisions of this article to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement or reimbursement rates by submitting a Statement of Disputed Issues to the Department in accordance with Section 51022.

Request for Hearing

Title 22, California Code of Regulations (CCR), Section 51022 states:

(a.) An institutional provider may request a hearing for any disputed audit or examination finding as follows:

(1.) A written request shall be filed with the Department within 60 calendar days of the receipt of the written notice of the audit or examination findings.

(2.) This request may be amended at any time during the 60 calendar day period.

(b.) A Non-institutional provider may request a hearing on any disputed audit or examination finding as follows:

(1.) A written request shall be filed with the Department within 30 calendar days of the receipt of the audit or examination finding.

(2.) This request may be amended at any time during the 30 calendar day period.

(c.) All late requests by either Institutional or Non-institutional providers shall be denied and the audit or examination findings deemed final unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d.) The request shall be known as "Statement of Disputed Issues." It shall be in writing, signed by the provider or the authorized agent, and shall state the address of the provider and of the agent, if any agent has been designated. A provider or the agent shall specify the name and address of the individual authorized on behalf of the provider to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this article. The Statement of Disputed Issues need not be formal, but it shall be specific as to each issue as are in dispute, setting forth the provider's contentions as to those issues and the estimated amount each issue involves. The information specified in subsection (e) shall also be included. If the hearing officer determines that a Statement of Disputed Issues fails to state the specific grounds upon which objection to the specific item is based, the provider or the agent shall be notified that it does not comply with the requirement of this regulation, and the reasons therefore.

(1.) An Institutional provider shall be granted 30 calendar days after the date of the mailing of the notice of

deficiency to the provider within which to file an amended Statement of Disputed Issues.

(2.) A Non-institutional provider shall be granted 15 calendar days after the date of mailing of the notice of deficiency within which to file an amended Statement of Disputed Issues.

(3.) If within the time permitted in (1) or (2) above, the Institutional or Non-institutional provider, respectively, or the agent fails to amend its appeal as notified, the appeal as to those issues shall be rejected.

(e.) The request shall also specify whether the provider does or does not wish that an informal level of review among the parties be held, together with the reasons therefore. Either party may request, or the hearing officer may order, that a telephone conference call be initiated among the parties for discussion of the advisability of conducting an informal level of review. The hearing officer shall decide whether an informal level of review would be appropriate and notify the parties of this decision in writing.

Beneficiary Fraud

Sharing of Medi-Cal Cards

Welfare & Institutions Code, Section 14026 states:

(a.) It is a misdemeanor for a Medi-Cal beneficiary to furnish, give, or lend his Medi-Cal card or labels to any person other than a provider of service as required under Medi-Cal regulations.

(b.) It is a misdemeanor for any person to use a Medi-Cal card other than the one which was issued to him or her to obtain health care services. This subdivision shall not apply to the use of a Medi-Cal card of a family member by another family member if the person using the card is, in fact, eligible under this chapter.

(c.) This section shall not apply to any peace officer while investigating Medi-Cal fraud or other crimes in performance of his official duties or to any person working under the peace officer's immediate direction, supervision, or instruction when such peace officer has been issued a Medi-Cal card pursuant to Section 14026.5.

Provider Assistance for Medi-Cal Fraud

Beneficiaries suspected of abusing the Denti-Cal program should be reported to the appropriate authorities. To help deter fraud, providers should be aware of the following:

- Individuals who are not residents of California.
- Individuals who give, lend or furnish their Medi-Cal cards to any person other than a Medi-Cal provider.

Note: This example does not apply to family members presenting a card on behalf of a Medi-Cal-eligible recipient to obtain services for that recipient (for example, a relative picking up a prescription for the recipient).

- Any attempt to obtain a prescription or controlled substance through misrepresentation or concealment.
- Individuals suspected of trying to obtain prescriptions to support their drug habit or for resale.
- Individuals who fail to report that they have other health coverage.
- Individuals who appear to have assets that would make them ineligible for Medi-Cal.

The Statewide Medi-Cal Fraud and Abuse Hotline for reporting recipients or providers is (800) 822-6222.

Section 9 - Special Programs

California Children's Services (CCS) 9-1
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Section 9 - Special Programs

California Children's Services (CCS)

The CCS program provides health care to children and adolescents under 21 years of age who have a CCS-eligible medical condition.

The CCS program provides diagnostic and treatment services, medical case management, some dental services, and physical and occupational therapy services. The CCS program only authorizes dental services if the beneficiary's CCS-eligible medical condition or oral condition can be affected. Examples of medical conditions of children who are CCS-eligible for dental services include cerebral palsy, cystic fibrosis, hemophilia, certain heart diseases, certain cancers, traumatic injuries to the face and mouth, cleft lip/palate, and other craniofacial anomalies. CCS offers orthodontics to children with medically handicapping malocclusions, cleft lip/palate, and craniofacial anomalies.

Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation. The referral to the CCS county program or CCS State Regional Office may be made by fax, phone call, correspondence, or the CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (CDHS 4516). CCS will not cover any services provided prior to the date the referral was received by the CCS program.

CCS serves approximately 175,000 children who have the following types of program eligibility:

- CCS/Medi-Cal: These beneficiaries are eligible for full scope dental benefits with no share of cost under Medi-Cal. They may have case coordination services provided by CCS. The provider shall submit TARs and Claims directly to Denti-Cal, comply with all program requirements and obtain prior authorization (when necessary) in order for services to be paid.
- CCS-only: These beneficiaries are children whose family's annual income is below $40,000, or whose estimated out-of-pocket expenses to treat the CCS eligible condition exceed 20% of a family's income. They receive health care funded by the State and the counties, and are limited to the treatment of their CCS-eligible conditions.

Genetically Handicapped Person's Program (GHPP)

The GHPP is a State-funded health care program for adults and some children with certain genetic diseases. GHPP coordinates care and payment for persons usually over the age of 21 years with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.

The GHPP serves adults and some children who have the following types of program eligibility:

- GHPP/Medi-Cal: These beneficiaries may be eligible for dental benefits under the GHPP.
- GHPP-only: These beneficiaries receive comprehensive State-funded dental and health care benefits under GHPP.

CCS-only and Authorizations and Claims Processing

To begin the CCS process for dental services, the provider must submit a CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (DHCS 4516) to the CCS county program. The provider may fax or mail this form to the CCS county program. The CCS county program will review the requested dental services and determine if the patient qualifies for the services based on their CCS-eligible medical condition.

Providers are required to obtain an approved SAR from the CCS county program of the beneficiary's county of residence, or CCS State Regional Office, prior to performing dental services. An approved SAR only authorizes the dental scope of benefits.

The CCS county program will issue a CCS SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date"

or after the “end date” indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of the Denti-Cal program.

Providers are to adhere to all Denti-Cal policies and TAR/Claim submission requirements. Refer to the Orthodontic Services Program in this section as well as “Section 5: Manual of Criteria and Schedule of Maximum Allowances” of this Handbook.

Providers do not have to attach the SAR to the Denti-Cal TAR/Claim. CCS electronically notifies Denti-Cal of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact CCS to obtain a new SAR prior to submitting a re-evaluation.

CCS/Medi-Cal Authorizations and Claims Processing

Beneficiaries with CCS/Medi-Cal eligibility do not require a CCS SAR. These beneficiaries have full scope Medi-Cal eligibility and are only case managed by CCS. No CCS SAR request should be submitted.

CCS/Medi-Cal claims and TARs are to be sent directly to Denti-Cal. CCS/Medi-Cal beneficiaries requiring dental benefits beyond the scope of the Denti-Cal program may submit a TAR requesting Early and Periodic Screening, Diagnosis, and Treatment-Supplemental Services (EPSDT-SS). Refer to EPSDT-SS in this section.

GHPP/Medi-Cal and GHPP-only Authorizations and Claims Processing

To begin the GHPP process for dental services, the provider must submit a GHPP Dental Client Service Authorization Request (SAR) (MC 2361) to the GHPP State office. The provider may fax or mail this form to the GHPP State office. The GHPP will review the requested dental services and determine if requested services are medically necessary.

The GHPP will issue a GHPP SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of the Denti-Cal program.

Providers are to adhere to all Denti-Cal policies and TAR/Claim submission requirements. Refer to "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Providers do not have to attach the SAR to the Denti-Cal TAR/Claim. GHPP electronically notifies Denti-Cal of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact GHPP to obtain a new SAR prior to submitting a re-evaluation.

Orthodontic Services for CCS-only Beneficiaries

The CCS program has adopted the Denti-Cal orthodontic criteria for children with handicapping malocclusion, cleft lip/palate and craniofacial anomalies. Orthodontic diagnostic and treatment criteria are contained within “Section 5: Manual of Criteria and Schedule of Maximum Allowances” for Medi-Cal Authorization (Dental Services) in this Handbook.

Providing Orthodontic Services to Denti-Cal Beneficiaries

In order to provide orthodontic services to Denti-Cal or CCS beneficiaries, a provider must be “actively” enrolled in the Denti-Cal program and be enrolled as a Certified Orthodontist. Refer to “Section 3: Enrollment Requirements” of this Handbook for additional information regarding enrollment. If the provider is uncertain of his/her current Denti-Cal status, he/she may phone the Denti-Cal Telephone Service Center

(800 423-0507) and request an Orthodontic Provider Enrollment Form.

As defined in Title 22, California Code of Regulations, Section 51223(c), a qualified orthodontist is a dentist who confines his/her practice to the specialty of orthodontics and has:

- Successfully completed a course of advanced study on orthodontics of two years or more in a program recognized by the Council on Dental Education of the American Dental Association, or
- Completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontics.

Eligibility

CCS:

CCS/Denti-Cal providers are to request an approved CCS SAR from the CCS county program or CCS State Regional Offices for CCS-only and dental services and then submit TAR/Claim forms to Denti-Cal.

CCS/Medi-Cal:

Denti-Cal providers are to submit TARs/Claims directly to Denti-Cal and do not require a CCS SAR.

GHPP:

GHPP providers are to request an approved GHPP SAR from the State GHPP office for GHPP/Medi-Cal and GHPP-only dental services and then submit TAR/Claim forms to Denti-Cal.

Note: CCS and GHPP SARs are not transferable between dental providers.

Changes in the Beneficiary's Program Eligibility

CCS-only, GHPP-only, CCS/Medi-Cal, and GHPP/Medi-Cal beneficiaries are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the AEVS, POS Device, and/or the Medi-Cal Web site: http:/www.medi-cal.ca.gov/. A beneficiary's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treating the beneficiary.

When the beneficiary changes from the CCS/Medi-Cal program to the CCS-only program, providers must obtain a SAR from the CCS county program. A SAR is not required for beneficiaries who change from the CCS-only program to CCS/Medi-Cal. Providers are to refer to this Handbook prior to treating CCS-only, CCS/Healthy Families, CCS/Medi-Cal, and GHPP/Medi-Cal beneficiaries.

Providers will need to submit separate claim forms when a patient's program eligibility changes. This will expedite Medi-Cal reimbursement in the event that a CCS county has insufficient funds to process claims with CCS-only or benefits. If the CCS county program/State GHPP program does not have sufficient funds, claims will be withheld until sufficient funds are available.

Note: CCS-only beneficiaries residing in Los Angeles County will not be issued a BIC.

Emergency Treatment

CCS-only Beneficiaries: If there is an emergency condition, then the provider may treat the beneficiary for the emergency. The provider is required to submit the appropriate form (CDHS 4488 or CDHS 4509) to the CCS county program or CCS State Regional Office by the next business day, requesting a SAR.

CCS/Medi-Cal Beneficiaries: Providers should refer to "Section 4: Treating Beneficiaries" of this Handbook for procedures for approval and payment for emergency dental services and for obtaining appropriate authorization for services dictated by emergency situations, which preclude timely advance requests for Denti-Cal TAR/Claim forms.

GHPP/Medi-Cal and GHPP-only Beneficiaries: If there is an emergency condition, then the provider may treat the beneficiary for the emergency. The provider is required to submit the appropriate form (MC 2361) to the State GHPP office by the next business day, requesting a SAR.

Other Coverage

A CCS or GHPP beneficiary may have other dental coverage (i.e., managed care or indemnity dental insurance coverage). Beneficiaries must apply their other coverage benefits prior to utilizing CCS or GHPP benefits. Other coverage will be considered as the primary carrier, and CCS or GHPP will be considered as the secondary carrier and payer of last resort.

CCS-only, GHPP/Medi-Cal and GHPP only Service Code Groupings (SCG)

An approved SAR will list the SCGs and/or the individual procedure code(s) based on the provider's requested treatment plan and the beneficiary's CCS or GHPP-eligible medical condition. These 18 SCGs are grouped by treatment plans and procedure codes to assist the CCS county program or CCS State Regional Office in authorizing services based on the beneficiary's CCS-or GHPP-eligible medical condition. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from the CCS county program or GHPP State office. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Denti-Cal scope of benefits.

SCG 01 – Preventive Dental Services
D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1352

SCG 02 – Orthodontic Services for Medically Handicapping Malocclusion
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 03 – Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 04 – Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0340, D0350, D0470, D8080, D8670, D8680

SCG 05 – Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

SCG 06 – Primary Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

SCG 07 – Mixed Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

SCG 08 – Permanent Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

SCG 09 – Oral Surgery Services
D1510, D1515, D1520, D1525, D1555, D5211, D5212, D7111, D7140, D7210, D7220, D7230, D7240, D7250, D9220, D9221, D9230, D9241, D9242, D9248, D9610

SCG 10 – Periodontic Services
D4210, D4211, D4260, D4261, D4341, D4342, D4910, D9110, D9220, D9221, D9230, D9241, D9242, D9248

SCG 11 – Endodontic Services
D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D9220, D9221, D9230, D9241, D9242, D9248

SCG 12 – Restorative Services
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3222, D3230, D3240, D9220, D9221, D9230, D9241, D9242, D9248

SCG 13 – Laboratory Crown Services
D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791, D9220, D9221, D9230, D9241, D9242, D9248

SCG 14 – Fixed Prosthetic Services
D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D9220, D9221, D9230, D9241, D9242, D9248

SCG 15 – Prosthetic Services for Complete Dentures
D5110, D5120, D5130, D5140, D5860

SCG 16 – Prosthetic Services for Cast Partial Dentures
D5213, D5214

SCG 17 – Prosthetic Services for Resin Partial Denture
D5211, D5212

SCG 18 – Dental Services under General Anesthesia

D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1352, D1510, D1515, D1520, D1525, D1555, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3222, D3230, D3240, D3310, D3320, D3330, D3346, D3347, D3348, D3410, D3421, D3425, D3426, D4210, D4211, D4260, D4261, D4341, D4342, D4910, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D9110, D9220, D9221, D9241, D9242, D9420

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CCS-only Benefits

The CCS and GHPP program have the same scope of benefits as the Denti-Cal program with a few exceptions: CCS-only, GHPP/Medi-Cal and GHPP only (if applicable) have additional benefits and modifications based on frequency and age limitations. The table below lists the additional benefits.

Note: The reimbursement rates are the same as those on the Denti-Cal Schedule of Maximum Allowances (SMA).

CDT-13 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D0210	Intraoral - complete series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic radiographic image	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	Cephalometric radiographic image	Allowed for final records for orthodontic treatment
D0350	Oral/facial images (includes intra and extraoral images)	A benefit for final records for orthodontic treatment
D0470	Diagnostic casts	One additional benefit for final records
D1120	Prophylaxis - child	A benefit 4 times per year for prophy or prophy/fluoride
D1206	Topical application of fluoride varnish	A benefit 4 times per year
D1208	Topical application of fluoride	A benefit 4 times per year
D1351	Sealant – per tooth	A benefit: First deciduous molars (B, I, L, and S)
D1351	Sealant - per tooth	A benefit: Second deciduous molars (A, J, K, and T)
D1351	Sealant – per tooth	A benefit: First bicuspids (5, 12, 21 and 28)
D1351	Sealant - per tooth	A benefit: Second Bicuspids (4, 13, 20, and 29)
D1352	Preventive resin restoration	A benefit: First deciduous molars (B, I, L, and S)
D1352	Preventive resin restoration	A benefit: Second deciduous molars (A, J, K, and T)
D1352	Preventive resin restoration	A benefit: First bicuspids (5, 12, 21 and 28)
D1352	Preventive resin restoration	A benefit: Second Bicuspids (4, 13, 20, and 29)
D1510	Space maintainer-fixed – unilateral	A benefit to hold space for missing permanent posterior tooth.
D1515	Space maintainer-fixed – bilateral	A benefit to hold space for missing permanent posterior tooth.
D1520	Space maintainer-removable – unilateral	A benefit to hold space for missing permanent posterior tooth.
D1525	Space maintainer-removable – bilateral	A benefit to hold space for missing permanent posterior tooth.
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	No age restrictions

CDT-13 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4261	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant	No age restrictions
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	No age restrictions
D4910	Periodontal maintenance	No age restrictions
D5110	Complete denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5120	Complete denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5130	Immediate denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5140	Immediate denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3rd molars.
D5212	Mandibular partial denture – resin base (including any conventional clasps, rest and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3rd molars.
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5860	Overdenture – complete, by report	A benefit once every year up to age 21 with appropriate documentation due to growth

Contact Listings for Denti-Cal, Medi-Cal Eligibility, GHPP, and CCS

Denti-Cal Program Providers are to contact the Denti-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and GHPP-only questions related to payments of claims and/or authorizations of TARs.	
Provider Toll-Free Line	(800) 423-0507
Beneficiary Toll-Free Line	(800) 322-6384
Electronic Data Interchange (EDI) Support	(916) 853-7373
Ordering Denti-Cal Forms	Fax (877) 401-7534
Medi-Cal Program Providers are to contact the Medi-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only and GHPP-only eligibility, POS, or Internet questions.	
Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk, POS, and/or Internet Help Desk	(800) 541-5555
Internet Eligibility Web Site	http://www.medi-cal.ca.gov/
GHPP State Office Providers are to contact the State GHPP office for questions related to authorizations for services issued prior to January 31, 2011.	
Toll Free	(800) 639-0597
Toll	(916) 327-0470
Fax	(916) 327-1112
Genetically Handicapped Persons Program: MS 8200 PO Box 997413 Sacramento, CA 95899	

CCS-only County Programs and CCS State Regional Offices

CCS Web site and contact information:

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Providers are to utilize the following guidelines when selecting the correct CCS county program or CCS State Regional Office:

- For questions on eligibility, SAR authorizations, and submitting claims in Independent counties, please contact the CCS Independent county office listed on the CCS Web site: http://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx
- For questions on eligibility in Dependent counties, please contact the CCS Dependent county office or the appropriate CCS State Regional Office listed above.
- For questions on prior authorization or submitting claims in Independent counties, contact the appropriate CCS State Regional Office listed above.

GHPP/Medi-Cal and GHPP-only State Office

GHPP Web site and contact information:

http://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx

Orthodontic Services Program

Denti-Cal Program benefits include medically necessary orthodontic services. Services available under this program are limited to only those beneficiaries that meet the general policies and requirements. These benefits are available to eligible individuals before their 21st birthday. Policies governing the provision of these program benefits are listed in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Qualified orthodontists may provide orthodontic services to eligible Medi-Cal and California Children's Services (CCS) beneficiaries. California Code of Regulations, Title 22, Section 51223(c) defines a "qualified orthodontist" as a dentist who "confines his/her practice to the specialty of orthodontics, and, who either has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association" or "who has completed advanced training in orthodontics prior to July 1, 1969 and is a member of, or eligible for membership in the American Association of Orthodontists."

Enrollment and Orthodontic Certification

1. A provider must be actively enrolled as a Denti-Cal provider to qualify for participation in this program. An orthodontist who wishes to submit claims for services provided to eligible Denti-Cal and/or CCS beneficiaries must first complete an Orthodontia Provider Certification form. For an enrollment application and information, call Denti-Cal at (800) 423-0507.
2. Complete the Orthodontia Provider Certification form and return it promptly to Denti-Cal. Denti-Cal will enter an appropriate code on an automated provider record to establish and identify the provider under the Orthodontic Services Program.
3. The provider will be notified in writing when the certification has been approved**. Orthodontic services provided to Medi-Cal beneficiaries prior to an approved certification will not be paid by Denti-Cal**.
4. Denti-Cal will furnish an initial supply of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheets (DC016) upon certification approval. Additional Score Sheets may be obtained through the Denti-Cal forms supplier by checking the appropriate box on the Denti-Cal Forms Reorder Request.

Initial Orthodontic Evaluation and Completion of the HLD Index Score Sheet

An initial orthodontic examination called the Limited Oral Evaluation (Procedure D0140) must be conducted. This examination includes completion of the HLD Score Sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the patient qualifies for medically necessary orthodontic services. Follow the instructions on the back of the form to assess the medical necessity (example in "Section 6: Forms" of this Handbook). The qualifying conditions for treatment under the Denti-Cal Orthodontic Program are:

1. Cleft palate deformities.
2. Craniofacial anomaly. (A description of the condition from a credentialed specialist must be attached.)
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite under the Orthodontic Services Program.)
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with reported masticatory and speech difficulties. Submit photographs for this exception.

6B. Individual score of at least 26 points.

Children who do not meet the Manual of Criteria requirements for orthodontic services may still be covered if services are documented as medically necessary under the Early and Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT-SS) Regulations. See the EPSDT-SS Exception on the bottom of the HLD Score Sheet (DC016) and attach the required supporting documentation in addition to completing the "conditions" section of the form. Refer to the EPSDT-SS Request for Orthodontic Services of this section for clarification of qualifying factors for EPSDT-SS.

If one of the above conditions is present, Diagnostic Casts (Procedure D0470) may be provided for beneficiaries. (Note: Diagnostic Casts are payable only upon authorization of orthodontic treatment plan.)

The Orthodontic Evaluation (Procedure D0140) and/or the Diagnostic Casts (Procedure D0470) do not require prior authorization from Denti-Cal. Please note that all other orthodontic services do require prior authorization.

Diagnostic Casts

Diagnostic Casts (Procedure D0470) are required documentation for all handicapping malocclusion and cleft palate treatment plan requests. Exception: If the patient has a cleft palate that is not visible on the diagnostic casts, submission of the casts to Denti-Cal is not required. However, photographs or documentation from a credentialed specialist must be submitted.

Craniofacial anomalies cases do not require the submission of diagnostic casts for treatment plan requests, but do require documentation from a credentialed specialist.

Casts must be of diagnostic quality. To meet diagnostic requirements, casts must be properly poured and adequately trimmed to allow placement into centric occlusion. No large voids or positive bubbles should be present. Casts should be completely dry to prevent mold from forming. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

Careful packaging will help ensure that the casts arrive at Denti-Cal in good condition. Denti-Cal receives many broken and damaged casts due to poor packaging, which causes processing delays. Use a box that has sufficient packaging material (such as styrofoam "peanuts," shredded newspaper, "bubble wrap," etc.) so that the casts will not be jarred or bumped during shipping. Also,

place packaging materials between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

Additionally, diagnostic casts should be clearly labeled with proper identification so they can be matched with the correct TAR. This identification should clearly indicate:

- the patient's name,
- Client Index Number (CIN) or Benefits Identification Card (BIC) number, and
- the dentist's name.

If the casts are received without patient identification, they will be destroyed.

Only duplicate or second pour diagnostic casts should be sent to Denti-Cal. The casts will not be returned. Diagnostic casts of denied cases will be kept in the Denti-Cal office for 30 days following a denial and up to one year off-site to enable the provider to request a reevaluation.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for the diagnostic casts and the TAR for orthodontic treatment. The diagnostic casts should be packaged separately for mailing to Denti-Cal at the same time as the claim and TAR to the address on the TAR/Claim form. Unless otherwise directed, do not send casts to alternate addresses as they can be misdirected or lost.

Clarification of Case Types

Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If a malocclusion case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photographs and documentation.

Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition phase, and again in the permanent dentition phase. If the cleft palate cannot be demonstrated on the diagnostic casts, documentation from a credentialed specialist must be attached.

If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 10 quarterly visits, a maximum of 5 additional quarters may be authorized upon review of progress photographs and documentation.

If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Craniofacial Anomaly Cases

Craniofacial anomalies cases may also be treated from birth in the primary dentition phase, again in the mixed dentition, and again in the permanent dentition phase. Documentation from a credentialed specialist is required for all craniofacial anomaly cases. Submission of the diagnostic casts is optional.

Procedure D8660 – Pre-orthodontic Treatment Visits (maximum of 6 quarters) are optional, and are a benefit only for craniofacial anomaly cases to monitor the patient's dentition and/or facial growth prior to starting orthodontic treatment.

If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photographs and documentation.

If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Orthodontic Treatment Plans

1. A complete orthodontic treatment plan must be submitted to request prior authorization. The orthodontic treatment plan must include:
   a) TAR:
      - Comprehensive orthodontic treatment of the adolescent dentition (D8080)
      - Periodic orthodontic treatment visit(s) (D8670)
      - Note: Document the case type and dentition phase in the comment section (box 34).
      - Orthodontic retention (D8680)
      - Any necessary radiographs such as complete series (D0210) or Panoramic radiographic image (D0330), and cephalometric radiographic images (D0340) should also be requested on the TAR.
   b) HLD Score Sheet
   c) Diagnostic Casts

   Note: For craniofacial anomalies cases only: If Pre-orthodontic treatment visits (Procedure D8660) are necessary prior to starting orthodontic treatment, indicate the quantity and attach all appropriate documentation to the TAR for the complete orthodontic treatment plan.
2. The Denti-Cal orthodontic consultant will evaluate the HLD Score Sheet, and the diagnostic casts or documentation (as applicable for cleft palate and craniofacial anomaly cases) to determine if the case qualifies for treatment under the Denti-Cal guidelines for orthodontic services.

Treatment Plan Authorization and Payment Submission Procedures

1. When the TAR for orthodontic services is approved by Denti-Cal, a series of Notices of Authorization (NOAs) will be issued confirming authorization. NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. A calendar quarter is defined as:
   a) January through March
   b) April through June
   c) July through September
   d) October through December

   These NOAs should be used for billing purposes.

2. Each calendar quarter when services are provided, submit one NOA to Denti-Cal for payment.

   Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080).

   Note: On or after July 1, 2008, each incidence of Procedure D8670 will be paid once per quarter. Only one NOA with a date of service in a given quarter needs to be submitted in order to receive the quarterly payment. Treatment visits may occur at any frequency deemed necessary during the quarter to complete the active phase of treatment, e.g., monthly, bimonthly, quarterly.

   NOAs for payment will be processed in accordance with general Denti-Cal billing policies and criteria requirements for Orthodontic Services. Please remember that authorization does not guarantee payment. Payment is subject to patient eligibility.

   Note: If payment of an NOA is denied, submit a Claim Inquiry Form (CIF) for reevaluation. Do not resubmit for the same date of service using a new NOA.

3. Request a reevaluation for prior authorization of treatment only on a denied NOA for the orthodontic treatment plan. NOAs for the active phase of treatment and retention may not be reevaluated.
4. Under the Denti-Cal orthodontic program, confirmation of continued treatment is required at the end of each 12 months of authorized treatment. Denti-Cal will send a Resubmission Turnaround Document (RTD) requesting a signature to confirm continued treatment for the subsequent 12 months or remaining treatment. Indicate treatment will continue by signing the RTD. If the RTD is not returned according to Denti-Cal policies, the request for continued treatment will be disallowed. A new TAR must then be submitted for all remaining treatments.

Helpful Hints

The following is important information regarding eligibility when providing orthodontic treatment:

Beneficiary eligibility must be current for each month, and must cover orthodontic benefits.

A beneficiary seeking orthodontic treatment may have a SOC obligation to meet each month.

A beneficiary may have coverage under another plan that includes orthodontic services. Beneficiaries with other dental coverage must still have orthodontic services authorized under the Denti-Cal program.

Each request for payment must have the Explanation Of Benefits (EOB), fee schedule or letter of denial attached.

The information may state that the beneficiary is enrolled in a special project or prepaid health plan that includes orthodontic treatment. Refer to “Section 7: Codes” of this Handbook for additional information and a list of current special project codes and prepaid health plan codes.

Refer to “Section 4: Treating Beneficiaries” of this Handbook for complete information on beneficiary eligibility and procedures for verifying eligibility.

Transfer Cases

When transferring from one certified Denti-Cal orthodontist to another certified Denti-Cal orthodontist, prior authorization is necessary before continuing treatment.

Transfer of a case in progress by another carrier also requires prior authorization.

Original diagnostic casts, along with new casts or progress photographs and any other documentation must be submitted for evaluation.

Diagnostic casts are not required if the treatment has already been approved by Denti-Cal.

Only orthodontic cases that meet the program criteria will be authorized for the remaining treatment which will be determined by the Denti-Cal orthodontic consultant.

Treatment Plan Authorization and Payment Submission Procedures

When additional orthodontic services are required or there is a change in the authorized treatment plan, submit a new TAR with documentation and any NOAs that have not been used. Mark all unused NOAs for deletion.

- If the orthodontic treatment is completed in less time than originally authorized, then document this on the NOA for the final quarterly visit.
- If there are remaining NOAs for quarterly visits but there is no NOA for retainers, then submit all of the outstanding NOAs for deletion and attach a new TAR for upper and lower retainers along with the request for payment.
- If billing on the NOA for the retainers, then document that the treatment has been completed ahead of schedule and attach any remaining NOAs for deletion.
- When a new TAR is authorized by Denti-Cal, the provider will receive a series of NOAs confirming the authorization. Use the new NOAs for billing purposes.

The TAR submitted for Procedures D8670 and D8660 must list the total quantity or frequency (number of quarters necessary to complete the treatment) in the "Quantity" field, column #30 and the total fee (fee for the procedure times the number of quarters) in the "Fee" field, column #32. The example above shows the correct way to list these procedures to ensure accurate calculation of the Notice of Authorization.

Frequency (# of treatments)

Total fee (# of treatments x UCR)

EXAMINATION AND TREATMENT

26. TOOTH #/LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Comprehensive Ortho Tx.			D8080	975.00	
		2 Periodic Ortho TX Visits		08	D8670	1000.00	
U		3 Retention		01	D8680	375.00	
L		4 Retention		01	D8680	375.00	
		5 Full Mouth Series			D0210	80.00	
		6					
		7					

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

EPSDT services are the current Denti-Cal Program's scope of benefits for beneficiaries under the age of 21. EPSDT was further defined by federal law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and includes dental services. In addition, Section 1905(4)(5) of the Social Security Act requires that a medically necessary health care service listed in Section 1905(a) be provided to an EPSDT beneficiary even if the service is not under a state's Medicaid plan to the rest of the Medicaid population.

The Department established regulations, effective on April 4, 1994, and amended effective April 27, 1995, to clarify the Department's implementation of the EPSDT program within Medi-Cal. The applicable regulations, contained within Title 22 of the California Code of Regulations, are Sections 51184, 51242, 51304, 51340, 51340.1 and 51532.

EPSDT: Frequently Asked Questions

What is EPSDT?

The early and periodic screening, diagnosis, and treatment (EPSDT) program is a special process within Denti-Cal specifically for children. Under federal law, EPSDT services are provided to any Medicaid beneficiary under age 21. For the Denti-Cal Program, this means medically necessary dental services provided for any Denti-Cal beneficiary who has not yet reached his or her 21st birthday are EPSDT services.

What Kind of Dental Services are Classified as EPSDT?

Whenever a Denti-Cal provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent dental treatment resulting from that examination is considered an EPSDT dental service if the dental procedure is published in the Denti-Cal Manual of Criteria.

Early and Periodic Screening, Diagnostic and Treatment Supplemental Services (EPSDT-SS)

EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program of benefits. Conversely, the dental service may be part of the Denti-Cal Program scope of benefits for adults but not for children or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal Program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).

What is an EPSDT Supplemental Service?

Medi-Cal enrolled children may need dental services that are not part of the scope of benefits found within the Manual of Criteria. Denti-Cal covers these services, too. In California, these services are called EPSDT Supplemental Services or "EPSDT-SS."

Example 1: John S. has a craniofacial anomaly with multiple edentulous areas. The edentulous areas cannot be adequately restored using conventional prosthetics – an implant-retained fixed prosthesis may be authorized as an EPSDT Supplemental Service.

EPSDT-SS also covers situations when the dental service being requested may be listed in the Manual of Criteria, but the child does not meet the published criteria.

Example 2: Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planing. The Manual of Criteria, however, states this procedure is not a benefit for patients under 13 years of age. The medically necessary periodontal procedures may be authorized as EPSDT Supplemental Services.

Example 3: Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive. With adequate supplemental documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT Supplemental Service.

Example 4: Andre W. does not qualify for orthodontic services per the handicapping malocclusion criteria (he scores below 26 points on the HLD Index Score Sheet or does not have one of the five automatic qualifying conditions). However, a speech pathologist has determined that his malocclusion is a prime etiologic factor in his speech pathosis – resolution cannot be achieved unless his malocclusion is corrected. In this case, orthodontics may be authorized as an EPSDT Supplemental Service.

When Would I Request an EPSDT Supplemental Service for My Child Patients?

You would request prior authorization for an EPSDT Supplemental Service under any one of the following conditions:

1) To perform a medically necessary dental procedure that is not listed in the current Manual of Criteria.
2) To perform a medically necessary dental procedure that is listed in the current Manual of Criteria when the child does not meet the published criteria.
3) The child needs a dental service more frequently than is currently allowed under Program criteria.

How Do I Request an EPSDT Supplemental Service?

All EPSDT Supplemental Services must be prior authorized and you MUST print "EPSDT Supplemental Services Request" in Field 34 of the TAR/Claim form. If the requested dental service is not listed within the Manual of Criteria, use the appropriate unspecified procedure code and fully describe the service. Do not limit your comments to Field 34 of the TAR/Claim form – attach all documents that are needed to describe the requested services.

What Kind of Clinical Information Does the Program Need to Determine the Medical Necessity?

At a minimum, you should address the following:

- Diagnosis of the dental condition
- Any overall health issues and medical conditions
- Prognosis with and without the requested treatment
- Clinical rationale for why a covered benefit or lower-cost service will not suffice (you are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale).

Note: Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging).

In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR/Claim.

It is virtually impossible to submit too much documentation with your TAR for EPSDT Supplemental Services!

Whom Can I Call to Obtain Further Information About the EPSDT and EPSDT-SS Requirements Under Denti-Cal?

Denti-Cal Telephone Service Center Representatives are available toll-free,

(800) 423-0507, to answer all of your questions regarding EPSDT services and EPSDT Supplemental Services.

EPSDT-SS Requests for Orthodontic Services

All EPSDT-SS requests for orthodontic services must include a completed Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet (DC016) in addition to the aforementioned documentation requirements. The review of active orthodontic services also requires the submission of diagnostic casts.

For detailed instructions on how to complete the HLD Index, refer to "Section 6: Forms" of this Handbook.

Non-Emergency Medical Transportation (NEMT)

Denti-Cal provides non-emergency transportation services to eligible Medi-Cal beneficiaries. Beneficiaries can request transportation from their homes to their appointed dental locations or other facilities; however, such requests are only approved for recipients who are eligible for Medi-Cal on the date of service and whose physicians or dentists have demonstrated medical necessity through prior authorization. Adjudication of claims will be subject to prior authorization and will be approved when the recipient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and the transportation is required for the purpose of obtaining necessary health care covered by the Medi-Cal program.

Denti-Cal providers are authorized to contact NEMT providers and submit all requests to transportation companies. The transportation company will then submit a TAR to the Department of Health Care Services (DHCS), Clinical Assurance and Administrative Support Division (CAASD), who will review and approve the TAR if medical necessity is demonstrated.

Please note that NEMT necessary for obtaining medical services is covered but subject to the written prescription of a physician, dentist, or podiatrist.

Denti-Cal providers are responsible for the submission of the Nonemergency Medical Transportation (NEMT) Required Justification form (DHCS 6182) to the pre-designated transportation companies and every TAR must be accompanied by a legible prescription or order sheet signed by the physician or dentist for the beneficiary. The prescription requirements must include the following:

1. Purpose of the trip
2. Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation
3. Medical or physical condition that makes normal public or private transportation inadvisable

Note: When transportation is requested on an ongoing basis, the chronic nature of a recipient's medical or physical condition must be indicated and a treatment plan from the physician or therapist must be included. A diagnosis alone, such as "multiple sclerosis" or "stroke," will not satisfy this requirement.

The Medi-Cal field office consultant needs the above information to determine the medical necessity of a specialized medical transport vehicle and the purpose of the trip. Incomplete information will delay approval.

Denti-Cal has provided a list of pre-designated transportation companies in each county for dental providers to contact. Providers are encouraged to refer to work with the NEMT companies if dental providers have questions.

A list of approved NEMT providers is attached to bulletin Volume 31, Number 8.

Section 10 - CDT 13 Tables

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Section 10 - CDT 13 Tables

Effective June 1, 2014, Current Dental Terminology 13 (CDT 13) was implemented which created changes to the Federally Required Adult Dental Services (FRADS), Pregnancy, Omnibus Budget Reconciliation Act (OBRA) beneficiary emergency, and Beneficiary Cap procedures.

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes are reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older.

Please note: The procedure codes marked with an asterisk (*) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0250*	Extraoral - first radiographic image
D0260*	Extraoral - each additional radiographic image
D0290*	Posterior - anterior or lateral skull and facial bone survey radiographic image
D0310*	Sialography
D0320*	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330	Panoramic radiographic image
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay, onlay, or partial coverage restoration
D2920	Recement crown
D2940	Protective restoration
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6100	Implant removal, by report
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
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)
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

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
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
D7465	Destruction of lesion(s) by physical or chemical method, by report
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)

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
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
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
D7876	Arthroscopy - surgical: debridement
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy – segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
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/anxiolysis, 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

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 13 Code	CDT 13 Code Description
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
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 3: Restored Adult Dental Services (RADS)

Effective May 1, 2014 some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82).

Table 3: Restored Adult Dental Services (RADS)

CDT13 Code	CDT 13 Code Description
D0150	Comprehensive oral evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0274	Bitewings - four radiographic images
D0330	Panoramic radiographic image
D0350	Oral/Facial Photographic Images
D1110	Prophylaxis - adult
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride
D2140	Amalgam - One Surface, Primary or Permanent
D2150	Amalgam - Two Surfaces, Primary or Permanent
D2160	Amalgam - Three Surfaces, Primary or Permanent
D2161	Amalgam - Four or More Surfaces, Primary or Permanent
D2330	resin-based Composite - One Surface, Anterior
D2331	resin-based Composite - Two Surfaces, Anterior
D2332	resin-based Composite - Three Surfaces, Anterior
D2335	Resin-based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)
D2390	Resin-based Composite Crown, Anterior
D2391	Resin-based Composite - One Surface, Posterior
D2392	Resin-based Composite - Two Surfaces, Posterior
D2393	Resin-based Composite - Three Surfaces, Posterior
D2394	Resin-based Composite - Four Or More Surfaces, Posterior

Table 3: Restored Adult Dental Services (RADS)

CDT13 Code	CDT 13 Code Description
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth
D2932	Prefabricated Resin Crown
D2933	Prefabricated Stainless Steel Crown With Resin Window
D2952	Post And Core In Addition To Crown, Indirectly Fabricated
D2954	Prefabricated Post And Core In Addition To Crown
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)
D3346	Retreatment Of Previous Root Canal Therapy - Anterior
D5110	Complete Denture – Maxillary
D5120	Complete Denture – Mandibular
D5130	Immediate Denture – Maxillary
D5140	Immediate Denture – Mandibular
D5410	Adjust Complete Denture - Maxillary
D5411	Adjust Complete Denture – Mandibular
D5510	Repair Broken Complete Denture Base
D5520	Replace Missing Or Broken Teeth – Complete Denture (Each Tooth)
D5610	Repair Resin Denture Base
D5730	Reline Complete Maxillary Denture (Chairside)
D5731	Reline Complete Mandibular Denture (Chairside)
D5750	Reline Complete Maxillary Denture (Laboratory)
D5751	Reline Complete Mandibular Denture (Laboratory)
D5850	Tissue Conditioning, Maxillary
D5851	Tissue Conditioning, Mandibular
D5860	Overdenture – Complete, By Report

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

Those who qualify for Medi-Cal benefits as OBRA beneficiaries have limited benefits are only eligible for emergency dental services.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part.

The emergency must be certified in accordance with California Code of Regulations, Title 22, Section 51056.

Please note that TARs are not allowed and may not be submitted for these beneficiaries. If a TAR is submitted for any of the procedures described below, it will be denied.

The following are identified as emergency dental procedures for OBRA beneficiaries:

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 13 Code	CDT 13 Code Description
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0250	Extraoral - first radiographic image
D0260	Extraoral - each additional radiographic image
D0290	Posterior - anterior or lateral skull and facial bone survey radiographic image
D0330	Panoramic radiographic image
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

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 13 Code	CDT 13 Code Description
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)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 13 Code	CDT 13 Code Description
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

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 13 Code	CDT 13 Code Description
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
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

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 13 Code	CDT 13 Code Description
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/anxiolysis, 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
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report

Table 5: Exempt Dental Services

The following procedures have been identified as always exempt from the $1800 dental cap limitation.

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D0502	Other oral pathology procedures, by report
D2910	Recement inlay, onlay, or partial coverage restoration
D2920	Recement crown
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5660	Add clasp to existing partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular
D5860	Overdenture - complete, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6053	Implant/abutment supported removable denture for completely edentulous arch

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D6054	Implant/abutment supported removable denture for partially edentulous arch
D6055	Connecting bar - implant supported or abutment supported
D6056	Prefabricated abutment - includes modification and placement
D6057	Custom fabricated abutment - includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078	Supported fixed denture for completely edentulous arch
D6079	Implant/abutment supported fixed denture for partially edentulous arch
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semiprecision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6094	Abutment supported crown (titanium)
D6095	Repair implant abutment, by report
D6100	Implant removal, by report
D6194	Abutment supported retainer crown for FPD (titanium)
D6199	Unspecified implant procedure, by report
D6930	Recement fixed partial denture
D6980	Fixed partial denture repair, necessitated by restorative material failure
D6999	Unspecified fixed prosthodontic procedure, by report
D7260	Oroantral fistula closure
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D7286	Biopsy of oral tissue - soft
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)
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

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 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
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: debridement
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)

Table 5: Exempt Dental Services

CDT 13 Code	CDT 13 Code Description
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7980	Sialolithotomy
D7983	Closure of salivary fistula
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7999	Unspecified oral surgery procedure, by report

Table 6: Exempt Emergency Dental Services

The following procedure codes may be exempt from the dental cap limitation if they are related to an adequately documented emergency service:

Table 6: Exempt Emergency Dental Services	
CDT 13 Code	**CDT 13 Code Description**
D0160	Detailed and extensive oral evaluation - problem focused by report
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0240	Intraoral - occlusal radiographic image
D0250*	Extraoral - first radiographic image
D0260*	Extraoral - each additional radiographic image
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0274	Bitewings - four radiographic images
D0290*	Posterior - anterior or lateral skull and facial bone survey radiographic image
D0330	Panoramic radiographic image
D0999	Unspecified diagnostic procedure by report
D1550	Recementation of space maintainer
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
D3240	Pulpal therapy (resorbable filling) - posterior primary tooth (excluding final restoration)
D3999	Unspecified endodontic procedure by report
D4920	Unscheduled dressing change (by someone other than treating dentist)
D4999	Unspecified periodontal procedure by report
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth - complete denture (each tooth)
D5610	Repair resin denture base
D5620	Repair cast framework

Table 6: Exempt Emergency Dental Services	
CDT 13 Code	**CDT 13 Code Description**
D5630	Repair or replace broken clasp
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D6100	Implant removal by report
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)
D7261	Primary closure of a sinus perforation
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
D7465	Destruction of lesion(s) by physical or chemical method by report
D7530	Removal of foreign body from mucosa skin or subcutaneous alveolar tissue
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches

Table 6: Exempt Emergency Dental Services	
CDT 13 Code	**CDT 13 Code Description**
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7990	Emergency tracheotomy
D8691	Repair of orthodontic appliance
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9120	Fixed partial denture sectioning
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/anxiolysis 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
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances by report

Table 6: Exempt Emergency Dental Services	
CDT 13 Code	**CDT 13 Code Description**
D9999	Unspecified adjunctive procedure by report

Section 11 - Glossary

Effective June 1, 2014, Current Dental Terminology 13 (CDT 13) was implemented which created changes to the Federally Required Adult Dental Services (FRADS), Pregnancy, Omnibus Budget Reconciliation Act (OBRA) beneficiary emergency, and Beneficiary Cap procedures.

Adjudication	A term that refers to the final resolution of a document in the Denti-Cal claims processing system.
Adjudication Reason Code	A code specific to a claim service line reflecting the reason for modification or denial.
Amount Billed	The amount the provider has billed for each claim line.
Arch Integrity	There is arch integrity when there are sufficient proximate natural teeth in a restorable condition which would afford the opposing arch adequate or satisfactory occlusion for masticatory function.
Asynchronous Store and Forward	The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. Photographs taken by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan. Source: Business and Professions Code Division 2, Chapter 5, Article 12, Section 2290.5 (a)(6)
Attachments	Radiographs, photographs, or other documentation submitted with a claim, TAR or NOA.
Automated Eligibility Verification System (AEVS)	The on-line system for verifying Medi-Cal patient eligibility for a given month of service.
Balance	Lack of posterior balanced occlusion is defined as follows: a. Five posterior permanent teeth are missing (excluding 3rd molars), or b. All four 1st and 2nd permanent molars are missing, or c. The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
Beneficiary	A person eligible to receive Medi-Cal benefits.
Benefit	Dental or medical health care services covered by the Medi-Cal program.
Benefits Identification Card (BIC)	A permanent plastic identification card issued to a person certified to receive Medi-Cal benefits. The card identifies the person by name and includes an identification number and signature. The back of the card contains a unique magnetic strip similar to that on a credit card, designed to be used with a special point-of-service device to access the Medi-Cal automated eligibility verification system, enabling the dental office to immediately confirm the patient's eligibility for Medi-Cal benefits at the time of service.
Billing Provider	The provider who bills or requests authorization for services on the treatment form.
Bounded Tooth Spaces	Edentulous spaces in the arch with at least one tooth on each side (mesial and distal).
California Children's Services (CCS)	CCS provides diagnostic and treatment services, medical case management, dental services, and physical and occupational therapy services. CCS only authorizes dental services, if such services are necessary to treat the beneficiary's CCS-eligible condition. Examples of medical conditions of children who are CCS-eligible include cystic fibrosis, hemophilia, heart disease, cancer, traumatic injuries, handicapping malocclusion, cleft lip/palate, and craniofacial anomalies.

CalWORKs	California Work Opportunity and Responsibility to Kids Program (CalWORKs) is California's welfare reform program, implementation provisions of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
Child Health and Disability Prevention (CHDP)	The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. Source: http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx
Client Index Number (CIN)	A 10-digit Medi-Cal beneficiary identifier that appears on the Medi-Cal identification card.
Claim Inquiry Form (CIF)	The Claim Inquiry Form (CIF) is used by the provider to inquire about the status of a TAR or Claim or to request reevaluation of a modified or denied claim.
Claim Inquiry Response (CIR)	The CIR is a computer-generated form used to explain the status of the TAR or Claim.
Clinical Screening Dentist	A licensed dentist who reviews claims and Treatment Authorization Requests (TARs) at the request of Denti-Cal and provides clinical evaluations as to their merits.
Clinical Screening Reports	Reports submitted by Clinical Screening Dentists who participate in the Denti-Cal clinical screening network.
Contiguous Teeth	Teeth that are touching or adjacent to each other
Correspondence Reference Number (CRN)	An 11-digit number assigned to each incoming CIF or correspondence that identifies it throughout the processing system.
County Medical Services Program (CMSP)	The County Medical Services Program (CMSP) is a unique county/state partnership formed to provide for the medical and dental care needs of individuals 21-64, residing in California's 34 rural counties, now administered by Doral Dental Services.
Current Dental Terminology (CDT)	CDT is a reference manual published by the American Dental Association (ADA) that contains a number of useful components, including the Code on Dental Procedures and Nomenclature (Code), instructions for use of the Code, Questions and Answers, the ADA Dental Claim Form Completion Instructions, and Tooth Numbering Systems. The Code, published in the CDT reference manual, provides the dental profession with a standardized coding system to document and to communicate accurate information about dental treatment procedures and services to agencies involved in adjudicating insurance claims. CDT and the Code are used in dental offices and by the dental benefits industry for purposes of keeping patient records, reporting procedures on patients and processing and reporting of dental insurance claims, and in developing, marketing and administering dental benefit products. The Code is generally updated every two years. The updated code is published in a new edition of the CDT. Source: http://www.ada.org/ada/prod/catalog/cdt/index.asp On August 17, 2000 the Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure code from the version of the Code in effect on the date of service. The Code is also used on dental claims submitted on paper, and the ADA maintains a paper claim form whose data content reflects the HIPAA standard electronic dental claim. Source: http://ada.org/prof/resources/topics/cdt/index.asp

Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system.
Document Control Number (DCN)	A unique 11-digit number assigned to each claim or TAR and used to identify the document throughout the processing system.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	EPSDT services are the current Denti-Cal Program's scope of benefits for beneficiaries under the age of 21.
Explanation of Benefits (EOB)	A statement accompanying each payment to providers that itemizes the payments and explains the adjudication status of the claims.
Fair Hearing	See State Hearing.
Federally Required Adult Dental Services (FRADS)	Per Federal law requirements, the Federally Required Adult Dental Services (FRADS) are services by a dentist which a physician could reasonably provide.
Genetically Handicapped Person's Program (GHPP)	The GHPP is a State-funded program coordinating care and payment for selected dental services for persons 21 years of age or older with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.
Global	Treatment performed in conjunction with another procedure which is not payable separately.
Health Care Provider	A person who is licensed under this division.
Health Insurance Portability and Accountability Act (HIPAA)	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system will improve the use of electronic data interchange. Source: http://www.cms.hhs.gov/HIPAAGenInfo/
Interactive Telecommunications System	Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site health care provider.
IRCA/OBRA	Legislation for the Denti-Cal Program to pay for specific services provided for certain alien recipients who were previously ineligible for these benefits. The federal Immigration Reform and Control Act of 1986 (IRCA) and the Omnibus Budget Reconciliation Act of 1986, 1989 (OBRA) have extended limited or full-scope dental benefits for newly legalized amnesty aliens and/or undocumented aliens who are otherwise eligible for Medi-Cal but are not permanent U.S. residents under color of law. The services include emergency medical care, emergency dental care, and pregnancy-related services.
Julian Date	Claims received by Denti-Cal are dated using the Julian calendar, in which a number is assigned to a day rather than using the month/day/year format. Julian calendar dates are 001 to 365 (366 for a leap year).
Manual of Criteria (MOC) for Medi-Cal Authorization (Dental Services)	The document that defines criteria per California Code of Regulations (CCR), Title 22, Section 51003, for the utilization of dental services under the Denti-Cal Program. It provides parameters to providers treating Medi-Cal beneficiaries. It sets forth program benefits and clearly defines limitations, exclusions, and special documentation requirements.
Medicaid	A state-option medical assistance program that includes federal matching funds to states to implement a single comprehensive medical care program.
Medi-Cal	California's name for its Medicaid program.

Medi-Cal Benefits ID Card Number (BIC)	A 14-digit number for everyone EXCEPT CCS, whose number is 10 digits.
Medi-Cal Dental Program Provider Handbook (Handbook)	A reference guide prepared by Denti-Cal and the Department and distributed to all providers enrolled in the Denti-Cal Program. It contains the criteria for dental services; program benefits and policies; and instructions for completing forms used in the Denti-Cal program.
Medically Indigent (MI)	A person previously eligible for Medi-Cal benefits who was not eligible for such benefits under the Public Assistance or Medically Needy program. This means the MI individual did not meet the age criterion for eligibility (age 65 or older) even though he or she may have been deprived, disabled or in medical need. Most services provided under the adult portion of the MI program were 100 percent State funded; some MI individuals were required to share in the cost of services provided them. Under recent legislation, responsibility for medically indigent adults over the age of 21 who are not in long-term care facilities, who are not pregnant and who are not under refugee medical assistance, was transferred to the counties.
National Provider Identifier (NPI) Number	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. Covered entities may invoke contingency plans after May 23, 2007, and guidance about contingency plans may be found in the Downloads section below. Source: http://www.cms.hhs.gov/NationalProvIdentStand/
Notice of Authorization (NOA)	A computer-generated form sent to providers in response to their request for authorization of services.
Originating Site	A site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.
Other Coverage	When a Medi-Cal recipient's dental services are also fully or partially covered under other state or federal dental care programs, or under other contractual or legal entitlements, e.g., a private group or individual indemnification program.
Period of Longevity	The period of longevity in dentistry is considered to be the length or duration of acceptable service.
Prepaid Health Plan (PHP)	An organized system of health care that provides one or more medical services to an enrolled population for a predetermined capitated rate paid in advance.
Prior Authorization	A request by a provider for Denti-Cal to authorize services before they are performed. Providers receive a Notice of Authorization (NOA) from Denti-Cal, which they use to bill for services after they are performed.
Procedure Code	A code number that identifies specific medical or dental services with allowed amounts listed on the Schedule of Maximum Allowances (SMA).
Provider	An individual dentist, Registered Dental Hygienist in an Alternative Practice (RDHAP), dental group, dental school or dental clinic enrolled in the Medi-Cal program to provide health care and/or dental services to Medi-Cal eligibles.
Provider Master File (PMF)	The file in the Denti-Cal automated system which contains a record of each provider or dental group enrolled in and certified to provide dental services under the Denti-Cal Program.

Recipient	A person who has received Medi-Cal benefits.
Rendering Provider	The dentist whose services are billed under the billing provider's name and billing provider number. The rendering provider can also be referred to as the "treating provider."
Resubmission Turnaround Document (RTD)	A computer-generated form that Denti-Cal sends to the provider to request missing or additional information needed to complete processing of a claim, TAR or NOA.
Schedule of Maximum Allowances (SMA)	A listing of procedure codes with descriptions and maximum amount allowed for reimbursement of services.
Share of Cost (SOC)	The dollar amount that some Medi-Cal recipients must pay or obligate toward medical services before being certified as eligible for Medi-Cal.
State Hearing	A State Hearing is a legal process that allows beneficiaries to request a reevaluation of any denied or modified Treatment Authorization Request (TAR). It also allows a beneficiary or provider to request a reevaluation of a reimbursement case.
Surface	Refers to portions of teeth to be restored.
Teledentistry	The mode of delivering dental health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's dental health care while the patient is at the originating site and the health care provider is at a distant site.
Supernumerary Teeth (Hyperdontia)	Extra erupted or unerupted teeth that resemble teeth of normal shape
Third Party Liability	When a Denti-Cal service is also the object of an action involving tort liability of a third party, Worker's Compensation Award, or casualty insurance claim payment.
Title 22 (Division 3, of the California Code of Regulations [CCR])	Contains the rules and regulations governing the Medi-Cal program, and defines and clarifies the provisions of State statute, chiefly the Welfare and Institutions Code.
Tooth Code	A code that identifies each tooth by a number or letter.
Treating Provider	See definition of rendering provider found above.
Treatment Authorization Request (TAR)/ Claim	The form used by a provider when requesting authorization to perform a service or to receive payment for said service. TAR/Claim forms are required for certain services and under special circumstances.
Treatment Plan	A statement of the services to be performed for the patient. Dental history, clinical examination and diagnosis are used as the basis to arrive at a logical plan to eliminate or alleviate the patient's dental symptoms, problems and diseases, and prevent further degenerative changes.
Treatment Series	A treatment series means all care, treatment, or procedures provided to a patient by the individual practitioner.
UCR Fee	Usual, customary, and reasonable fee.
Welfare and Institutions (W & I) Code	The State of California code of law that includes Medi-Cal statutes and laws.

Section 12 - Bulletin Index

The following pages index the bulletins released December 2015 through November 2016, including the volume and number of the bulletin. This index indicates on which page(s) of the Provider Handbook the bulletin information has been incorporated.

Consider retaining in this section any bulletins which will help you more effectively provide services to beneficiaries while remaining in compliance with the regulations set forth by the California Medi-Cal Dental Program.

Previously released bulletins can be found on the "Denti-Cal Provider Bulletins" page of the Denti-Cal Web site: http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=BulletinsMain.

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