CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Safety Net Clinics (SNCs)
Frequently Asked Questions (FAQs)

Safety Net Clinics are referred to as Federally Qualified Health Centers, Rural Health Clinics, and Indian Health/MOA 683 Clinics.

I. Dental Policy

Question	Answer
1. Safety Net Clinic (SNC) policy guidelines indicate that the number of appointments for treatment should be in line with other health care delivery systems. Our clinic, however, has a policy that increases the number of appointments to deliver treatment, for example by separating dental examinations and dental prophylaxis. Is that acceptable?	Your clinic's policies should align to the SNC policy guidelines which are consistent with the Medi-Cal Dental Provider Handbook and outlined in the SNC Policy Training which is published on the Medi-Cal Dental website. Any deviation from these policies must be documented in the patient record and must be specific to the patient and the situation that requires more visits. The Medi-Cal Dental Provider Handbook notes, in part: To improve efficiency and timely access to care, maintain quality of care for a patient, a treating dental provider shall, when applicable, feasible, and consistent with the standard of care, minimize the number of dental visits. Each patient should receive an individualized treatment plan that is safe, effective, patient-centered and equitable. A Medi-Cal patient should not, as a matter of routine, expect to have to return for more visits than is consistent with the Medi-Cal Dental Provider Handbook. All dental services provided must be sufficiently documented in the patient medical record or electronic health record to indicate the medical reason/justification to bring the patient back to the clinic for a separate visit to complete the procedure. Please refer to Medi-Cal Dental Provider Handbook Section 4 - Treating Beneficiaries, Section 5 - Manual of Criteria (MOC), Section 8 - Fraud, Abuse, and Quality of Care.
2. Does Medi-Cal require a Registered Dental Hygienist in a SNC to have everything signed off by a dentist?	The Registered Dental Hygienists must comply, at a minimum, with the requirements outlined by the Dental Hygiene Board of California and the SNC's policies and procedures.

Question	Answer
3. What are the requirements to establish a dental program in a FQHC?	An FQHC that establishes a new dental program must secure the Health Resources Services Administration (HRSA) approval (refer to Bureau of Primary Health Care Scope of Project and Provider Information Notice (PIN) HRSA PIN 2008-1). When an FQHC adds dental services to serve Medi-Cal beneficiaries, a Change in Scope of Services Request (CSOSR) may be required. Please refer to Welfare & Institutions Code (WIC) 14132(e)(3)(C).
4. Does a dentist, who is employed or contracted by a SNC, need to enroll in Medi-Cal to bill for dental services?	Dental providers employed by a SNC must be enrolled in the Medi-Cal Dental program by completing the DHCS 6216 form. This enrollment process satisfies the Medi-Cal provider requirement for SNCs to enroll their Ordering, Referring, and Prescribing Providers. Additionally, contracted private practice dentists rendering services on behalf of SNCs must submit a DHCS 6216 form. Notably, all contracted private practice dentists rendering services on behalf a SNCs must also adhere to the Medi-Cal Dental Provider Handbook, the applicable Dental Board of California statutes and regulations, and Medi-Cal documentation and treatment plan requirements.

II. Billing and Data Submission

Question	Answer
5. I employ a treatment technique that is usually completed in one appointment by most providers. I have an alteration to this technique that requires multiple visits. Will I be paid for multiple visits?	No, as a matter of routine, multiple visits will not be covered especially when best practice dictates a one-visit procedure. Treatment plans that include more than the usual number of visits should not be provided as a matter of routine but should be specific and individualized to a particular patient needs and circumstances. Evaluation for coverage will be on a case-by-case basis and based on appropriate documentation. All dental services provided must be sufficiently documented in the patient medical record or electronic health record to indicate the need to deviate from the

Question	Answer
	standard that necessitate the altered technique. Please refer to: Medi-Cal Dental Provider Handbook Section 4 - Treating Beneficiaries, Section 5 - Manual of Criteria (MOC), Section 8 - Fraud, Abuse, and Quality of Care.
6. We expected this procedure to take a certain number of appointments, but it will take more appointments to complete. Is this allowable?	The medical necessity for each visit must be reflected in the patient record. Treatment plans that include more than the usual number of visits should not be provided as a matter of routine but should be specific and individualized to a particular patient needs and circumstances. All dental services provided must be sufficiently documented in the medical record or electronic health record to indicate the medical reason/justification to bring the patient back to the clinic for a separate visit to complete the procedure. Please refer to: Medi-Cal Dental Provider Handbook Section 4 - Treating Beneficiaries, Section 5 - Manual of Criteria (MOC), Section 8 - Fraud, Abuse, and Quality of Care.
7. Is it required to complete a prophylaxis on the same day as comprehensive new patient exam?	A comprehensive exam is completed for a new patient for the initial examination and after 36 months from the last periodic oral evaluation (D0120) or comprehensive oral evaluation (D0150) per patient per provider. A comprehensive exam does not require a prophylaxis to be completed in the same visit; however treatment plans must optimize preventive and therapeutic care. It must also be in the patient's best interest and in consideration of their overall health status. Moreover, the needed treatment services must be documented in patient medical record or electronic health record. Treatment plans must also be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner. Please refer to the SNC Policy Training. Additionally, please refer to the Manual Of Criteria (MOC) for specific criteria.

Question	Answer
8. Is it required to complete a prophylaxis on the same day as a periodic exam for adult patients?	Definitive services such as prophylaxis and periodic exams should be completed within a single appointment. When definitive services are not completed within a single appointment, it must be documented in the patient medical record or electronic health record as to why a second visit was necessary. Please refer to the SNC Policy Training for more information. For specific criteria questions, please visit the Manual Of Criteria (MOC).
9. As a SNC provider, we do not submit TARs to Medi-Cal Dental. Do we need to use the Justification of Need for Prosthesis form (DC054)? What about the DC016 Handicapping Labio-Lingual Deviation form for orthodontics?	SNC providers are required to have the same level of justification and documentation that is required for TAR authorization and approval. There is an underlying requirement that the dental criteria will be followed and documented. Both the Justification of Need for Prosthesis form (DC054) and Handicapping Labio-Lingual Deviation form (DC016) provide detailed information for medically necessary services. A completed DC054 and/or DC016 must be included in the patient record for documentation purposes. It is the clinic provider's responsibility to document conditions for determining the patient need for orthodontia and the initial placement or replacement of a prosthesis, as well as the patient ability to adapt to a prosthesis in the patient medical record or electronic health record. Please refer to the Medi-Cal Dental Provider Handbook.
10. How can I receive a copy of the Justification of Need Prosthesis form (DC054)?	The Justification of Need Prosthesis form (DC054) is available online under 'General' section on the Medi-Cal Dental Provider Forms website. You can also request and order the DC054 form, complete and send the Forms Reorder Request form via fax at (877) 401-7534 or mail to: Medi-Cal Dental Forms Reorder 11155 International Dr. MS C25 Rancho Cordova, CA 95670

Question	Answer
	If you are enrolled to submit electronically through Electronic Data Interchange (EDI), providers have the option to submit the DC054 form as an electronic attachment with a TAR.
11. Generally, what are the reimbursement requirements when dental services are provided to a Medi-Cal beneficiary?	The SNC provider must satisfy the requirements of a billable visit, comply with the Manual of Criteria (MOC), and the dental service determined to be medically necessary pursuant to California Welfare and Institutions Code (W&I Code), Section 14059.5. Documentation in the patient medical record or electronic health record should be consistent with the standards set forth in the Manual of Criteria (MOC) for Medi-Cal Authorization of the Medi-Cal Dental Program Provider Handbook and comply with all state laws. Please refer to the following provider manuals for more detailed information. FQHCs and RHCs • FQHC/RHC manual IHS-MOAs • IHS-MOA program manual Tribal FQHCs • Tribal FQHC manual
12. Which dental billing codes must be used when submitting a claim to the California Medicaid Management Information Systems (CA-MMIS)?	When dental services are payable by CA-MMIS, the FQHC or RHC will submit on the appropriate claim form using per-visit local billing code 03 for beneficiaries who are covered for their dental services under Medi-Cal FFS. For beneficiaries enrolled in a dental Managed Care Plan (MCP) in Sacramento County or Los Angeles County, the FQHC or RHC provider should submit on the appropriate claim form to CA-MMIS with the Medi-Cal Managed Care Differential Billing Code set 0521 T1015 SE. IHS-MOA and Tribal FQHCs providing services to Medi-Cal beneficiaries enrolled in a Dental Managed Care (DMC) plan in Los Angeles or Sacramento County will submit dental claims directly to the DMC plan when the services are rendered to Medi-Cal DMC plan members

Question	Answer
	(beneficiaries). No differential billing is required to CA-MMIS. Please refer to the following provider manuals • FQHC/RHC billing codes manual IHS-MOAs • IHS-MOA billing codes manual Tribal FQHCs • Tribal FQHC billing codes manual
13. How do SNC providers submit encounter data to receive the enhanced payment for the CalAIM initiatives?	Encounter data may be submitted to the Medi-Cal Dental Fiscal Intermediary (FI) either through Electronic Data Interchange (EDI) claims or proprietary paper claims. See the detailed instructions regarding SNC encounter data submissions on the CalAIM dental web page for instructions. The website provides detailed information on each initiative and SNC resources, such as the SNC Frequently Asked Questions. SNC participation and billing instructions can be found in the Dental SNC Provider Bulletin and you can also review Medi-Cal Dental Provider Bulletin Vol 38 No 1 for more information.
14. May a SNC provider bill a patient for a non-covered service on the same day the SNC bills for the dental covered service and will be receiving the Prospective Payment System rate (PPS) or All-Inclusive Rate (AIR) reimbursement?	A SNC provider may bill a patient for a non-covered dental service on the same day the clinic is billing for covered dental service and receiving the applicable PPS or AIR reimbursement. Performing multiple services on the same day can minimize the number of dental visits. The expectation would be that if multiple procedures can be done in one visit when some are medically necessary covered services and some are not, multiple covered services in the same visit should also be reflected in the treatment plan and dental record. The SNC provider is prohibited from billing Medi-Cal beneficiaries for any service covered by Medi-Cal, other than the applicable share of cost.

Question	Answer
	All dental services provided must be sufficiently documented in the patient medical record or electronic health record to indicate the medical reason for the services provided and justification for the visit. Medi-Cal dental providers are required by law to follow all instructions for billing Medi-Cal patients. Please refer to: • Business & Professions Code section 654.3 (d)-(j) • Medi-Cal Dental Provider bulletin (Volume 37, Number 18) • Medi-Cal Dental Member Handbook
15. For an orthodontist consultation, is it considered a billable office visit even if the orthodontist determines the patient does not qualify for coverage (which is determined at that time)?	When the SNC's orthodontist satisfies the requirements of a billable visit, the consultation is a reimbursable encounter even if the patient is not eligible for coverage. Notably, all dental services billed by a SNC provider that are rendered pursuant to a contract between the SNC and a contract dental provider, and reimbursed by Medi-Cal, must adhere to the Medi-Cal Dental Provider Handbook, and the applicable Dental Board of California statutes and regulations, Medi-Cal provider enrollment requirements, and documentation and treatment plan requirements. Please refer to the following provider manuals for more details on the definition of a visit. FQHCs and RHCs • FQHC/RHC manual IHS-MOAs • IHS-MOA program manual Tribal FQHCs • Tribal FQHC manual
16. May a FQHC or RHC bill for two dental visits for the same patient in the same day at different locations (e.g. one visit with a dentist and one visit with a specialist)?	A FQHC or RHC may not bill for two dental visits on the same day for the same patient at different locations. However, more than one visit may be billed on the same day (which may be at a different location) only when a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment. All dental services provided must be sufficiently documented in the patient medical record or electronic

Question	Answer
	health record to indicate the illness or injury suffered by the patient that required another diagnosis or treatment. A Tribal FQHC may be reimbursed for up to three visits per day, per recipient, in any combination of three different medical, mental health, dental and ambulatory services.
17. May a FQHC or RHC bill separately for Registered Dental Hygienist services?	A FQHC or RHC may separately bill for Registered Dental Hygienist services with an approved Change in Scope-of-Service Request (CSOSR) Form 3096 on file, which is available online on the DHCS Audits and Investigation Division (A&I) Forms and Documents website.
18. What is the proper way to bill for emergency services?	Emergency services in of itself, is not treated any differently than a routine visit. Whether the patient is treated after business hours or seen without an appointment, the reimbursement is the same. All dental services provided must be sufficiently documented in the patient medical record or electronic health record to indicate the medical reason/justification to bring the patient back to the clinic for a separate visit to complete the procedure. Please refer to Medi-Cal Dental Provider Handbook Section 4 - Treating Beneficiaries, Section 5 - Manual of Criteria (MOC), Section 8 - Fraud, Abuse, and Quality of Care. The SNC provider will submit the claim using the appropriate per-visit local billing code 03 for beneficiaries enrolled in a FFS. For beneficiaries enrolled in a Dental Managed Care (DMC) plan in Sacramento County or Los Angeles County, the FQHC and RHC providers must submit to CA-MMIS the Medi-Cal Managed Care Differential Billing Code set 0521 T1015 SE. IHS-MOA and Tribal FQHCs will submit dental claims directly to the MCP when the services are rendered to Medi-Cal managed care beneficiaries. No differential billing is required to CA-MMIS. Please refer to the following provider manuals: • FQHC/RHC billing codes manual

Question	Answer
	IHS-MOAs • IHS-MOA billing codes manual Tribal FQHCs • Tribal FQHC billing codes manual
19. What assistance can a SNC provider receive if claims submitted for emergency services are denied?	When a claim for emergency service is denied, the SNC provider may contact CA-MMIS for guidance by calling the CA-MMIS TSC at 1-800-541-5555. SNC clinics that are contracted with Dental Managed Care (DMC) plans should have the DMC plan contact information and billing policy available. Refer to the FQHC/RHC provider billing codes manual for guidance and billing policies. Additionally, the steps for correcting claims with a billing error can be found in the 2022 Medi-Cal Billing Code Basic Handbook.
20. What is the proper way to bill for procedures that require multiple visits (i.e. dentures or endo)? Also, is it sufficient to record the CDT code in the patient's record for subsequent visits after the original visit? For example, enter in the patient's record CDT code D9430, which is an office visit for observation (during regular scheduled hours) - no other services were provided.	The SNC provider must satisfy the requirements of a billable visit. The billing must comply with the Manual of Criteria (MOC) and the dental service determined to be medically necessary pursuant to California Welfare and Institutions Code (W&I Code), Section 14059.5. It is not sufficient to merely record a CDT code in the patient's record for subsequent visits. Documentation in the patient medical record or electronic health record should be consistent with the standards set forth in the Manual of Criteria (MOC) for Medi-Cal Authorization of the Medi-Cal Dental Program Provider Handbook and comply with all state laws. SNC providers are required to indicate the medical reason/justification to bring the patient back to the clinic for a separate visit to complete a procedure. Please refer to Medi-Cal Dental Provider Handbook Section 4 - Treating Beneficiaries, Section 5 - Manual of Criteria (MOC), Section 8 - Fraud, Abuse, and Quality of Care.

Question	Answer
21. Can D9430 (Office visit for observation (during regularly scheduled hours) - no other services performed)be used for oral surgery and endodontic post-op visits?	D9430 (Office visit for observation (during regularly scheduled hours) - no other services performed) cannot be used for oral surgery and endodontic post-op[erative] visits. Routine post-op visits for surgical and endodontic procedures can and should be scheduled, but they are incident to the original procedure (i.e. extraction or root canal should not be billable as a separate encounter). DHCS expects the clinics' standard of practice is to follow up with your patient at no charge. However, if there is an unexpected complication, such as a post-operative infection, it should be justifiable and documented. And In this instance, it can be billable as a face-to-face encounter using the appropriate code CDT Code D9930 (treatment of complications (post surgical) – unusual circumstatnces, by report). Please refer to Section 5 - Manual of Criteria (MOC) for Oral and Maxillofacial Surgery General Policies and Endodontic General Policies.