THE

MEDI-CAL DENTAL PROGRAM

ORTHODONTIC SEMINAR PACKET

Revised 11/08/22

Dear Medi-Cal Dental Provider and Staff:

Welcome! We have prepared this packet especially for orthodontists and their staff who attend our provider training seminar for the Orthodontic Services Program under the California Medi-Cal Dental Program.

The material contained in this packet is designed to familiarize you with the Medi-Cal Dental orthodontic program utilizing the CDT 22 procedure codes, policies, procedures and billing requirements. For further information, please refer to the Provider Handbook located on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

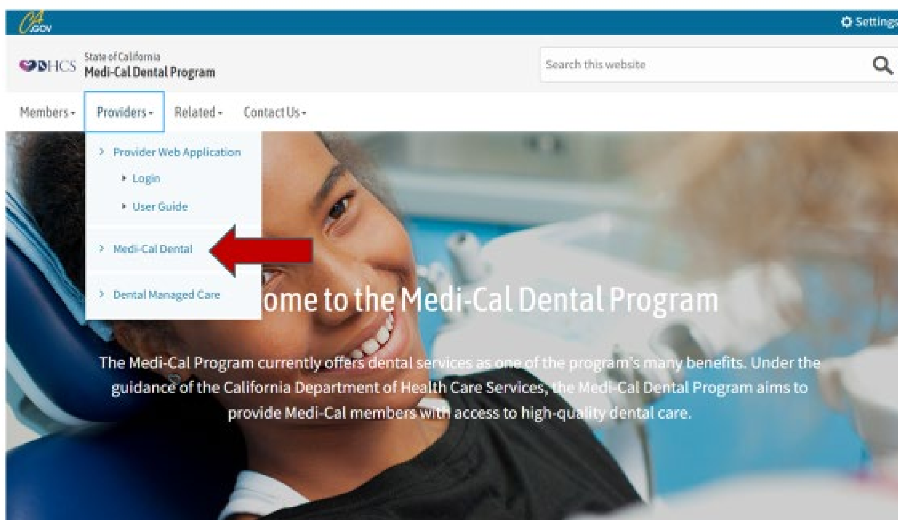
We appreciate your interest in the California Medi-Cal Dental Program and hope you will benefit from the information presented at today's seminar. If you have any questions, please call our toll-free number, (800) 423-0507.

Sincerely,

Medi-Cal Dental Program

P.O. Box 15609 • Sacramento, CA 95852-0609 • (800) 423-0507 • (916) 853-7373

The Medi-Cal Dental Website
www.dental.dhcs.ca.gov



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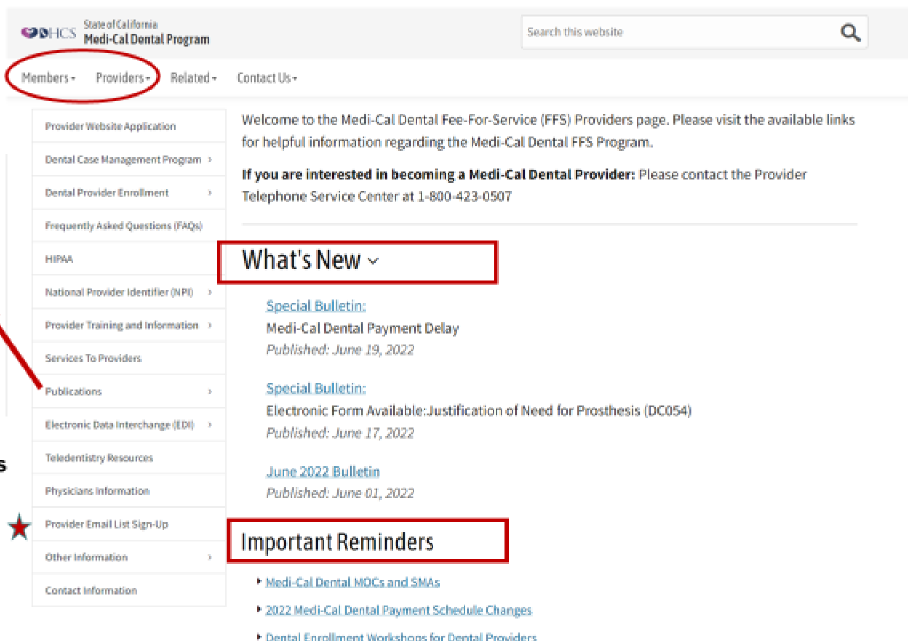
The Medi-Cal Dental Website

- Members and Providers tabs
- Publications
  - Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA)
  - Provider Bulletins
  - Provider Handbook
  - Provider Forms
  - Provider Website Application User Guide
  - Statutes and Regulations
- What's New
- Important Reminders



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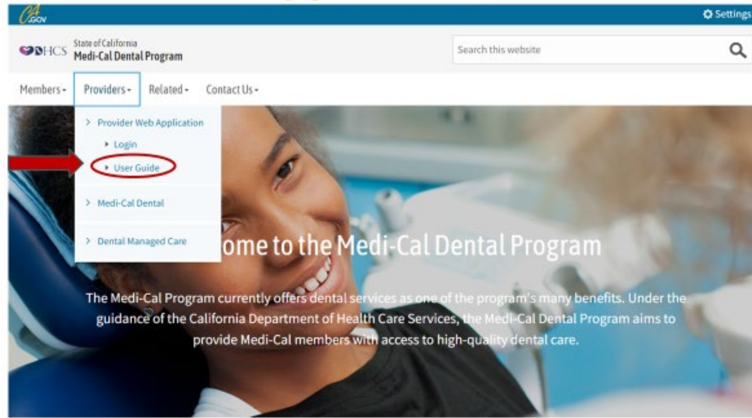
The Medi-Cal Dental Provider Website Application



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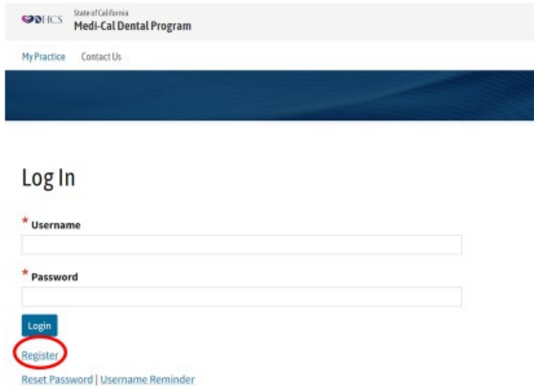
The Medi-Cal Dental Provider Website Application



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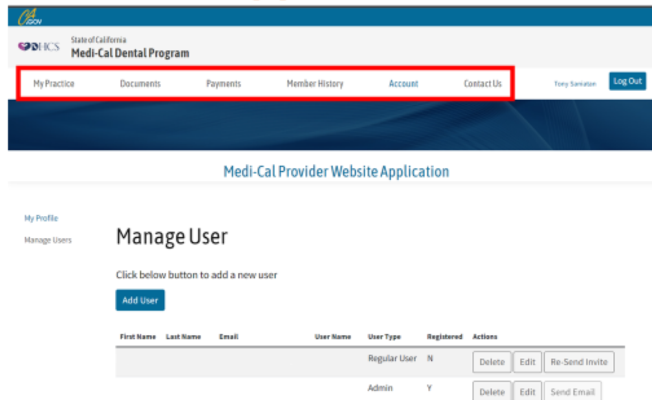
The Medi-Cal Dental Provider Website Application



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ORTHODONTIC PROGRAM

Orthodontic Program Benefits

- In February 1991, the Medi-Cal Dental program expanded it's benefits to include orthodontic care
- Orthodontic benefits are to age 21, with no extended benefits
- Are only provided for the following medically necessary conditions:
  - Handicapping Malocclusion
  - Cleft Palate/Lip
  - Craniofacial Anomalies

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Provider Handbook/Bulletins

The Medi-Cal Dental Provider Handbook and Medi-Cal Dental Bulletins are available on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

The Provider Handbook has been developed to assist the provider and office staff with participation in the Medi-Cal Dental Orthodontic Services program. It contains detailed information regarding the submission, processing and completion of all treatment forms and other related documents. The Handbook should be used frequently as a reference guide to obtain the most current criteria, policies and procedures of the California Medi-Cal Dental Program. For specific information on the Orthodontic Services Program, refer to Section 9: Special Programs.

The Handbook is updated on a monthly and/or quarterly basis. As updates are made, they will be incorporated into the Provider Handbook. A copy of the updates will appear in the "What's New' section of the Medi-Cal Dental website for printing purposes. The updates will include a cover letter with instructions on which pages or sections to replace.

The Medi-Cal Dental Bulletin is usually published on a monthly basis to keep providers informed of the latest developments in the program. The "Provider Bulletins" section of the website should be checked frequently for current and up-to-date information regarding the Medi-Cal Dental program.

Enrollment and Certification

- To participate in the Orthodontic program:

1. Providers must enroll as a Qualified Orthodontist,

and

2. Be in an 'active" Medi-Cal Dental enrollment status

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Certification for Medi-Cal Dental Orthodontist

Section 51223, Title 22, the California Code of Regulations defines a qualified orthodontist as meeting the following requirements:

- The Orthodontist must confine his/her practice to the specialty of orthodontics, and
- Has successfully completed a course of advanced study in orthodontics for two years or more in programs recognized by the council on dental education of the American Dental Association, or
- Has had advanced training in Orthodontics prior to July 1, 1969, and is a member of, or eligible for membership in the advanced American Association of Orthodontics

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National Provider Identifier (NPI) Numbers

- Obtain NPI numbers from National Plan and Provider Enumeration System (NPPES website) https://nppes.cms.hhs.gov/#/

  Type 1: Health Care Providers who are individuals, including dentists and hygienists, and sole proprietorships, regardless of multiple service office locations

  Type 2: Health Care Providers who are organizations, including dental practices, and/or individual dental practices who are incorporated
- Dental offices many need both Type 1 and Type 2 NPI numbers

  Examples:

  Individual dentists at one practice location where a Type 1 is needed for the dentist and a Type 2 for the practice if claims are submitted using the practice's name and Tax Identification Numbers (TINs). Multiple dentists are at one practice location where a Type 1 is needed for the dentists and a Type 2 for the practice if claims are submitted using the practice's name & TIN

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Enrollment

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Billing Providers

To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the 'Medi-Cal Dental Program'. Enrollment is completed through the Provider Application and Validation for Enrollment (PAVE) portal. The Provider Enrollment Division (PED) provides an online enrollment application process.

Note: Paper applications are not accepted and will be returned. Once the enrollment process is complete, the new billing provider will be informed of acceptance into the program which will include the Billing Provider number and a Personal Identification Number (PIN).

The new Billing Provider will also receive a starter packet of forms. Additional forms may be ordered by completing the 're-order form' found on the Medi-Cal Dental Website.

RENDERING PROVIDERS

Each dentist who treats Medi-Cal patients must be enrolled in the Medi-Cal Dental program. The Rendering Provider number will be the type 1 NPI number that the Dr. obtained from NPPES. Group and rendering providers will be required to complete an affiliation form within PAVE. The Rendering Provider number will go in Box 33 on your Claims and NOAs.

BILLING INTERMEDIARIES

Medi-Cal Dental accepts claims prepared and submitted by a billing service acting on behalf of a provider. The provider and the billing service must complete (The Medi-Cal Dental Provider and Billing Intermediary Application/Agreement). Once the process is complete the billing service will receive a registration number which must be included on all claim forms they submit on a doctor's behalf.

What is PAVE?

- PAVE: Provider Application and Validation for Enrollment System
  - Interactive
  - Web-based
  - Secure
- PAVE is for:
  - Providers who want to enroll in Medi-Cal Fee-for-Service
  - For already enrolled Fee-for-Service providers who need to update their enrollment accounts

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Enrollment Changes

- All changes to your practice and/or license must be completed through the DHCS PAVE website, within 35 days of the change.
- PAVE Application https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

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Enrollment Revalidation

- Compliance with Centers for Medicare and Medicaid Services (CMS) Final Rule;
- The Code of Federal Regulations, Title 42, Section 455.414 states:

  The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

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Enrollment Revalidation Application Process

- DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application. Revalidation notices will be mailed to the service address enrolled with Medi-Cal. All providers are required to re-validate in order to continue participating in the Medi-Cal Dental Program.
- Dental providers submit revalidation applications using PAVE For more information, please contact PED using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx. You can also call the PED Message Center at (916) 323-1945.

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Enrollment Assistance

- For Medi-Cal provider enrollment information, please contact Provider Enrollment Division (PED) using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
- Provider Enrollment Division (PED) Message center
  - Phone number: (916) 323-1945
  - For Application questions email: PAVE@dhcs.ca.gov or send a message in PAVE
- PAVE Technical support
  - PAVE Help Desk at (866) 252-1949. The Help Desk is available Monday-Friday from 8:00 am-6:00 pm, excluding State holidays. You can also use the PAVE Chat feature while in PAVE. Chat is available Monday-Friday from 8:00 am-4:00 pm, excluding State holidays.

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Enrollment Inquiries

For Medi-Cal provider enrollment information, please contact PED using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

You can also call the PED Message Center at (916) 323-1945. For PAVE application questions, email PED at PAVE@dhcs.ca.gov, or send a message in PAVE.

Revalidation Inquiries

Dental providers submit revalidation applications using PAVE. DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application. Revalidation notices will be mailed to the service address enrolled with Medi-Cal.

PAVE Technical Support

For PAVE technical support, please call the PAVE Help Desk at (866) 252-1949. The Help Desk is available Monday-Friday from 8:00 am-6:00 pm, excluding State holidays. You can also use the PAVE Chat feature while in PAVE. The Chat feature is available Monday-Friday from 8:00 am-4:00 pm, excluding State holidays.

Billing Inquiries and EFT Inquiries

Please call the Medi-Cal Dental Telephone Service Center (TSC) at (800) 423-0507. TSC Representatives are available Monday-Friday from 8:00 am-5:00 pm.

PIN Confirmation/Reset

To confirm or reset a PIN, send a written request to Medi-Cal Dental at PO Box 15609, Sacramento, CA 95852-0609. A PIN cannot be confirmed or reset over the telephone.

Electronic Funds Transfer (EFT)

- Medi-Cal Dental payments are deposited directly into a checking or savings account
- No more waiting for the mail service
- Notification of deposits will appear on the EOB
- Request Direct Deposit through PAVE

‘Electronic Funds Transfer’

DIRECT DEPOSIT

Medi-Cal Dental check-write is 1 per week on Thursdays. And funds are deposited directly into your bank account on Wed night, and they would be available to you on Thursday morning. (Rather than Sat. or Monday with a paper check)

1. Enroll in Electronic Funds transfer through PAVE
2. No more waiting for the mail (or problems with lost checks/postal problems.
3. Notification of deposits will appear on your EOBs which will still go to the office (or wherever the Dr. directs).

ELIGIBILITY

Eligibility of a member is determined by the local social services department in the county where the member resides. Eligibility is not determined by Medi-Cal Dental. Once eligibility has been determined, the information is forwarded to the State of California. This information then becomes available to Medi-Cal Dental for processing claims according to the eligibility established.

Members are issued a plastic Benefits Identification Card (BIC) when eligibility is established. The identification card is not a verification of eligibility, but rather a means by which the provider may obtain eligibility and share-of-cost information. The initial card given to the member may be replaced in case of loss or theft. Should this occur, the member should report it to his or her social worker, and a new card will be issued within 2 – 10 working days. Please note, the new card will be given a new issue date.

Verifying Member Eligibility

There are several ways eligibility may be established:

1. Automated Eligibility Verification System (AEVS) through a touch-tone telephone
2. Internet access (www.medi-cal.ca.gov)

This is where providers will utilize their PIN to access eligibility information. The member's ID card provides all the information necessary to access eligibility. The automated eligibility system will instruct which information needs to be entered. When the information is entered, a response verifying member information and eligibility status will be given. Information received will be:

1. Member’s last name
2. First name, or first initial
3. County code
4. Primary aid code
5. Secondary aid code (if applicable)
6. Other information: Medi-Cal eligible, other coverage information, pre-paid Health Plan (PHP) information, Health Maintenance Organization (HMO) Plans, Managed Care, Share-of-Cost, etc.
7. Eligibility Verification Confirmation (EVC) Number

Eligibility

- The County Department of Social Services establishes eligibility
- Information is transferred to the Department of Health Care Services (DHCS)
- Verify eligibility monthly
- Members turning 21 years of age
- Eligibility Verification Confirmation Number (EVC)

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Medi-Cal Benefits Identification Card (BIC)

State of California
Benefits Identification Card
ID No. 99999999999999
FIRST M. LAST
M mm dd yyyy Issue Date 01 11 05

First M. Last
SIGNATURE
This card is for identification ONLY. It does not guarantee eligibility. Carry this card with you to your medical provider. DO NOT THROW AWAY THIS CARD. Misuse of this card is unlawful.

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Eligibility

- The Medi-Cal program verifies eligibility
- Two ways to verify eligibility through the Point of Service (POS) Network
  1. Touch Tone Telephone (A.E.V.S.)
  2. Internet (www.medi-cal.ca.gov)
- Request a POS Network/Internet Agreement from the POS/Internet Help Desk or Medi-Cal

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Web Eligibility
www.medi-cal.ca.gov

DHCS | Medi-Cal Providers

Providers | Beneficiaries | Resources | Related | Contact Us | Search

Welcome to the Medi-Cal Provider Home

Medi-Cal Learning Portal

Medi-Cal Subscription Service

Medi-Cal Internet Transactions

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Web Eligibility
www.medi-cal.ca.gov

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Provider Enrollment
Enroll or re-enroll as a Medi-Cal provider

Transactions
Access automated provider services for claims, eligibility inquiry and other Medi-Cal services

New Provider
Welcome new providers, access content to help you get started with Medi-Cal

Publications
Access Medi-Cal Provider Manuals, Provider Bulletins and news

Outreach and Education
One-stop learning and resource center for Medi-Cal billers and providers

Medi-Cal Subscription Service
Free subscription service to keep you up-to-date with the latest Medi-Cal news

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Web Eligibility
www.medi-cal.ca.gov

Login to Medi-Cal

User ID

Password

Login

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Web Eligibility
www.medi-cal.ca.gov

Medi-Cal Transaction Services

Medi-Cal Rx is live on January 1, 2022. Please visit the Medi-Cal Rx site for additional information

Eligibility

Eligibility Benefit Inquiry (270) | Eligibility Benefit Response (271) | Multiple Subscribers

Single Subscriber | Share of Cost (SOC)/Spend Down Clearance

Claims

Appeal Status Inquiry | Claim Status Inquiry | Claim Status Request (276)

Claim Status Response (277) | Medical Services Reservation

Provider Services

Blood Factor Rates | Case Status Inquiry | Continuing Care Inquiry

Medical Supply Code Inquiry | National Drug Code Inquiry | Procedure Code Inquiry

Provider Checkwrite Inquiry

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Web Eligibility
www.medi-cal.ca.gov

Single Subscriber

* Indicates required field

Single Subscriber Eligibility

Swipe Card | * Subscriber ID

* Subscriber Birth Date | * Issue Date | * Service Date

mm/dd/yyyy | mm/dd/yyyy | mm/dd/yyyy

Submit

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Web Eligibility
www.medi-cal.ca.gov

DHCS | Medi-Cal Providers — Providers, Beneficiaries, Resources, Related, Contact Us, Search

Home | Transaction Services | Single Subscriber | Single Subscriber Response

Single Subscriber Response

Eligibility transaction performed by provider: on Thursday, January 13, 2022 at 4:52:39 PM

Eligibility Message: NO RECORDED ELIGIBILITY FOR REQUESTED DATE OF SERVICE 01/13/2022.

Subscriber ID:

Service Date: 01/13/2022 | **Subscriber Birth Date:**

Issue Date: 01/13/2022 | **Primary Aid Code:**

First Special Aid Code: | **Second Special Aid Code:**

Third Special Aid Code: | **Subscriber County:** -unknown

HIC Number:

Primary Care Physician Phone #: | **Service Type:**

Trace Number (Eligibility Verification Confirmation (EVC) Number):

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AID CODES

Know the aid code(s): Not everyone receiving Medi-Cal has full-scope benefits. A member may be given aid codes that reflect limited or restricted coverage. Some members are limited to medical benefits only, such as ambulatory pre-natal care services. An example of restricted benefits would be emergency or pregnancy-related services only. These members would not be eligible for orthodontic care under the Medi-Cal Dental program.

OTHER INSURANCE COVERAGE

The eligibility message may also indicate other coverage information if it applies. A member may have orthodontic benefits through another dental plan. Remember that Medi-Cal will always be the secondary carrier to all other coverage.

Each request for payment must include a copy of the Explanation of Benefits (EOB), fee schedule, or letter of denial from the other carrier. Even with other coverage, orthodontic treatment must still be prior authorized by the Medi-Cal Dental program.

If a member is enrolled in a Managed Care Plan (MCP), Prepaid Health Plan (PHP), or Health Maintenance Organization (HMO) that includes dental benefits, orthodontic treatment must be rendered by a provider enrolled in that plan. There is no coordination of benefits with the Medi-Cal Dental Fee-For-Service (FFS) program.

SHARE OF COST

Share-of-Cost (SOC) information will be given in the eligibility message if it applies to the member. A SOC message will specify how much the member must agree to pay before becoming eligible for Medi-Cal benefits for the month. SOC is a procedure the Department of Health Care Services developed to ensure that an individual or family meets a predetermined financial obligation before receiving Medi-Cal benefits. This procedure is used to compute the dollar amount to be applied to any health care costs. Health care costs could be dental, medical, hospital or pharmaceutical charges. Always use usual, customary and reasonable (UCR) fees. If the SOC has been met when an update has been entered in the eligibility system, it will reflect this information or show the amount remaining. When updating SOC, do so by procedure code, not by the total amount for the visit.

Refer to the Provider Handbook, Section 4: Treating members, for further information on Aid Codes, Other Insurance or Share-of-Cost.

INSTRUCTIONS FOR SHARE OF COST (SOC) CLEARANCE USING THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS)

To perform a SOC clearance using the AEVS, follow these steps:

- Call AEVS at 800-456-AEVS (2387)
- Enter the 6 digit PIN number (not the same as the NPI)
- Press ‘2’ for the share of cost menu
- Press ‘1’ to perform an update (clearance)
- Enter the member ID number, then the pound sign (#)
- Enter the 2 digit month and 4 digit year of the member’s birth date
- Enter the date of service, using 2 digits for the month, 2 digits for the day, and 4 digits for the year. (For example: Enter March 5, 2017 as 03 05 2017)
- Enter the appropriate procedure code using the CDT 22 code format, followed by the (#)
- Enter the total amount billed in the format of dollars followed by the star sign, and cents followed by the pound sign. (For example: $20.50 would be entered as 20*50#)

Verify that the amount is entered correctly by pressing ‘1’ for ‘yes’ or ‘2’ for ‘no’. If '2' is pressed, re-enter the amount. If '1' is pressed, enter the case number (if applicable) followed by the (#) sign.

If the SOC is not fully satisfied, the amount deducted and the amount remaining will be indicated.

If the SOC is satisfied, the following information will be received:

- The first 6 letters of the last name
- The first initial of the first name
- The Eligibility Verification Confirmation (EVC) number
- The county code
- The aid code
- The amount deducted
- A message indicating the SOC is certified (cleared)
- A message indicating what type of eligibility the member has and if there are any restrictions or limitations to benefits

Eligibility can be delayed when other health care providers do not report payments made by the member. Instruct the member to take their receipt of payment to their caseworker so an update may be done. An alternative is to contact the other health care provider and ask that the SOC be updated immediately on behalf of the member.

Additional Information

- Aid Code information may be found in the Medi-Cal Dental Provider Handbook or on the Medi-Cal website
  - ✓ Type of Benefits
  - ✓ SOC

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Managed Care Plans

✓ Member must go to a plan provider

Eligibility Message:
SUBSCRIBER LAST NAME: XXXXXX. EVC# 00000AKEOR. CNTY CODE: 19. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER:PHP-HLTH NET: MEDICAL CALL (800)000-0000. HPC: CALL (800) 000-0000 FOR HCP INFORMATION. PCP: DR. XXXXX XXXX CALL (000) 000-0000.
ACCESS DENTAL PLAN: DENTAL CALL (000) 000-0000

Name: Last, First M.	Subscriber ID: 90000000A
Service Date: MM/DD/YYYY	Subscriber Birth Date: MM/DD/YYYY
Issue Date: MM/DD/YYYY	Primary Aid Code: 00
First Special Aid Code:	Second Special Aid Code:
Third Special Aid Code:	Subscriber County: 19 – Los Angeles
HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number: OOOOOAKEOR	

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Other Insurance Coverage

Other Coverage

- Prepaid Health Plans (PHP) / Health Maintenance Organization (HMO)
- Indemnity Plans
- Medi-Cal Dental is always secondary carrier
- Other Coverage must be billed first

Eligibility Message: SUBSCRIBER LAST NAME: XXXXXX. EVC# 00000AKEOR. CNTY CODE: 11. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV. UNDER CODE V. CARRIER NAME: BLUE CROSS OF CALIFORNIA ID XXXX000XXX00. COV: OMIPDVR	
Name: Last, First M.	Subscriber ID: 90000000A
Service Date: MM/DD/YYYY	Subscriber Birth Date: MM/DD/YYYY
Issue Date: MM/DD/YYYY	Primary Aid Code: 00
First Special Aid Code:	Second Special Aid Code:
Third Special Aid Code:	Subscriber County: 11– Glenn
HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number: OOOOOAKEOR	

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Share of Cost

- Is a pre-set amount determined by the Department of Health Care Services (DHCS) for an individual or family
- Any Health Care Services may be used
- Updating SOC
- Case Numbers
- Non-Covered Services may be used to meet SOC

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250 Percent Working Disabled Program

- Members with aid code 6G
- The "Spend Down Obligation Amount" field is due to the 250 Percent Working Disabled Program, the message will state that the recipient is eligible for full-scope Medi-Cal
- The SOC amount is a premium that the recipient pays directly to the Department of Health Care Services (DHCS)
- Providers are not to collect SOC amounts from the Working Disabled Program recipients.
- www.dhcs.ca.gov/services/Pages/TPLRD_WD_cont.aspx

ORTHODONTIC BILLING FORMS AND PROCEDURES

Orthodontic services are limited to only those who meet the general policies and requirements for medically necessary handicapping malocclusion, cleft palate, or cranio-facial anomalies cases set forth in Title 22 of the California Code of Regulations. Eligibility for these services end when the member reaches the age of 21, with no extended services allowed.

In administering the California Medi-Cal Dental Program, Delta Dental's primary function is to process claims and Treatment Authorization Requests (TARs) submitted by providers for dental services performed for Medi-Cal members. It is the intent of Delta Dental to process claims and TARs as quickly and efficiently as possible. The forms used for billing as well as other related documents have been developed to simplify billing procedures. The forms, in both manual and computer-compatible formats, are available from the Medi-Cal Dental forms supplier at no charge to providers.

The Handbook contains detailed, step-by-step instructions for completing each of the Medi-Cal Dental forms. Section 6: Forms, contains a handy checklist to help complete treatment forms accurately. Section 9: Special Programs, contains detailed information specific to the orthodontic program, including procedures and orthodontic claims processing.

All incoming documents are received and sorted by Gainwell Technologies. Claims and TARs are separated from other incoming documents and general correspondence. Orthodontic treatment forms are assigned a unique 11-digit Document Control Number or DCN. The DCN is important because it identifies specific treatment forms so Medi-Cal Dental can tell exactly where it is in the processing system, what has been done to that point, and if appropriate, what needs to be done to reach the final point of authorization or payment. By knowing this information, Medi-Cal Dental can answer inquiries concerning the status of any treatment form received.

The dental office must accurately complete treatment forms to ensure proper and expeditious handling by The Medi-Cal Dental program. A form which is incomplete or inaccurate causes delays in processing and/or requests for additional information. Please ensure the required information is typed or printed clearly on the form.

Surveillance and Utilization Review Subsystem (S/URS)

Record Keeping Criteria for the Medi-Cal Dental Program:

1. Providers are responsible for keeping original diagnostic casts for orthodontic services available upon request from DHCS during the course of approved treatment. Providers shall keep the diagnostic casts for a minimum of 2 years after the case is completed.
2. Complete members treatment records shall be retained for 10 years from the date the service was rendered and must be readily retrievable upon request.
3. Records shall include documentation supporting each procedure provided including, but not limited to:
   - Type and extent of services, and/or radiographs demonstrating and supporting the need for each procedure provided
   - Indicate the type of materials used, anesthetic type, dosage, vasoconstrictor and number of carpules used
   - Include the date and ID of the enrolled provider who preformed the treatment
4. Emergency services must have written documentation which includes, but is not limited to, the tooth/area, condition and specific treatment performed. The statement; 'An emergency existed' is NOT sufficient.

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CDT 22 Procedures codes

- D0140 = Limited oral evaluation
- D0470 = Diagnostic casts
- D8080 = Comprehensive orthodontic treatment of the adolescent dentition (for all case type - fees will vary)
- D8660 = Pre-Orthodontic treatment visit (for craniofacial anomalies cases only)
- D8670 = Periodic orthodontic treatment visit (for all case types – fees will vary)
- D8680 = Orthodontic retention (for all case types)

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Clarification of Case Types

Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If malocclusion cases require further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review. Progress photos must be submitted when requesting additional visits.

Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition, and again in the permanent dentition phase. Submission of the diagnostic casts is not required if the cleft palate cannot be demonstrated on the casts. However, photographs or 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 photos 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 photos 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 photos 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 permanent dentition. Submission of the diagnostic casts for the authorization of the treatment plan is optional. Documentation from a credentialed specialist is required for all craniofacial anomalies' cases. 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 photos 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 photos 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 photos 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.

Note: Craniofacial Anomalies cases may require Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6) to monitor the facial growth on a quarterly schedule prior to starting orthodontic treatment. This procedure is not required if the member's

dentition or skeletal growth is stable, and the member is ready to start orthodontic treatment. Submit this procedure (x the number of visits requested) along with the TAR for the complete orthodontic treatment plan.

Clarification of Case Types Malocclusion Cases:

- Permanent dentition (or at age 13)
- 8 quarterly visits (initial request)
- Possible extension = maximum of 4 additional quarters (submit progress photographs & documentation)

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Clarification of Case Types Cleft Palate Cases:

- Primary dentition = 4 quarterly visits (initial request)
  - Possible extension = maximum of 2 additional quarters (submit progress photographs and documentation)
- Mixed dentition = 5 quarterly visits (initial request)
  - Possible extension = maximum of 3 additional quarters (submit progress photographs and documentation)
- Permanent dentition = 10 quarterly visits (initial request)
  - Possible extension = maximum of 5 additional quarters (submit progress photographs and documentation)

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Clarification of Case Types Craniofacial Anomaly Cases:

- Primary dentition = 4 quarterly visits (initial request)
  - ➢Possible extension = maximum of 2 additional quarters (submit progress photographs and documentation)
- Mixed dentition = 5 quarterly visits (initial request)
  - ➢Possible extension = maximum of 3 additional quarters (submit progress photographs and documentation)
- Permanent dentition = 8 quarterly visits (initial request)
  - ➢Possible extension = maximum of 4 additional quarters (submit progress photographs and documentation)

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The 1st Step…

The 1st step for Orthodontic treatment is to provide the Ortho Exam:

D0140 = Limited Oral Evaluation

The exam includes completion of the 'Handicapping Labio-Lingual Deviation (HLD) Index CA Modification Score Sheet'

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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 ________

<u>AUTHORIZATION OF SERVICES IS BASED ON MEDICAL NECESSITY. IF A PATIENT DOES NOT HAVE ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS OR DOES NOT SCORE 26 OR ABOVE, THE PATIENT MAY STILL BE ELIGIBLE FOR THESE SERVICES BASED ON EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) CRITERIA NECESSARY TO CORRECT OR AMELIORATE THE PATIENT'S CONDITION. FOR A FURTHER EXPLANATION OF EPSDT CRITERIA, PLEASE SEE THE ORTHODONTICS SECTION OF THE CALIFORNIA MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK.</u>

DC016 (R 09/18)

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.**

EPSDT

- Early and Periodic Screening, Diagnostic, and Treatment Services
- In accordance with the Social Security Act and federal regulations, DHCS must provide full-scope Medi-Cal members under age 21 with a comprehensive, high-quality array of preventive, diagnostic, and treatment services under EPSDT

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EPSDT

- EPSDT services might or might not be part of the Manual of Criteria
- A service is medically necessary if it corrects or ameliorates defects and physical and mental illnesses or conditions

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EPSDT

- A TAR is required when a procedure is not listed in the Manual of Criteria, or a service does not meet the published criteria for a procedure
  - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition

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EPSDT Sample

- Example: Andre W. (age 13) 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 six 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 service.

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EPSDT

Consideration for EPSDT exception: Any case demonstrating the presence of

- Pathology
- An impacted or unerupted tooth destroying the root of an adjacent tooth
- Attachment loss associated with anterior crossbite

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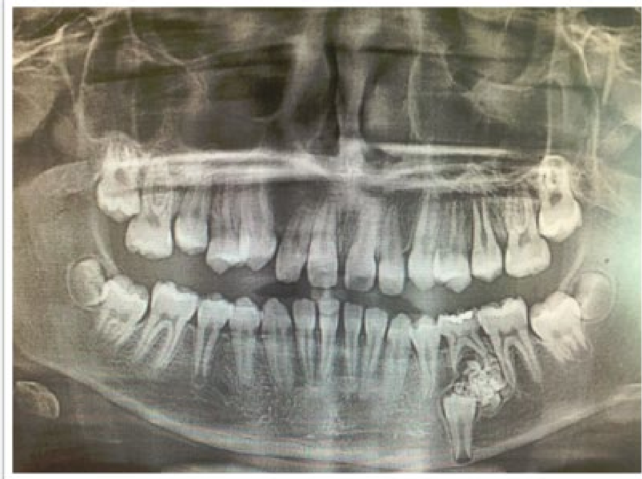
Pathology



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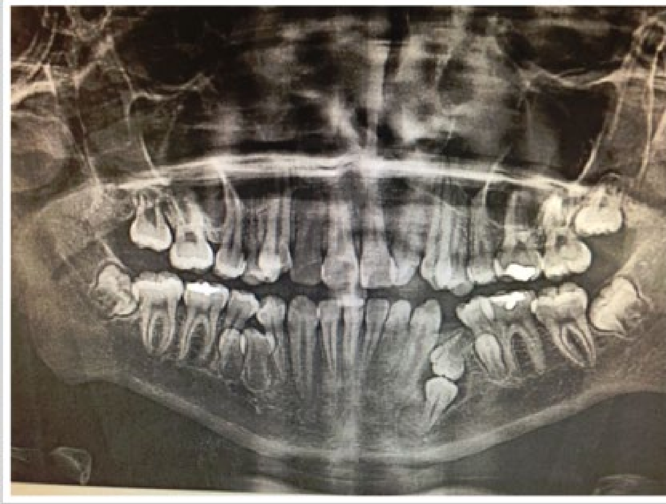
Pathology



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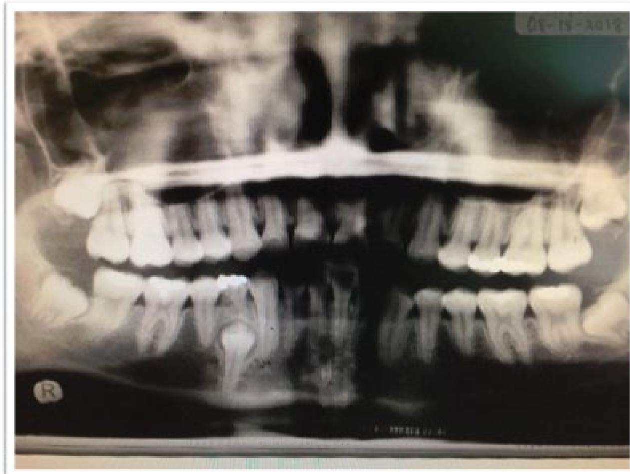
Not Pathology



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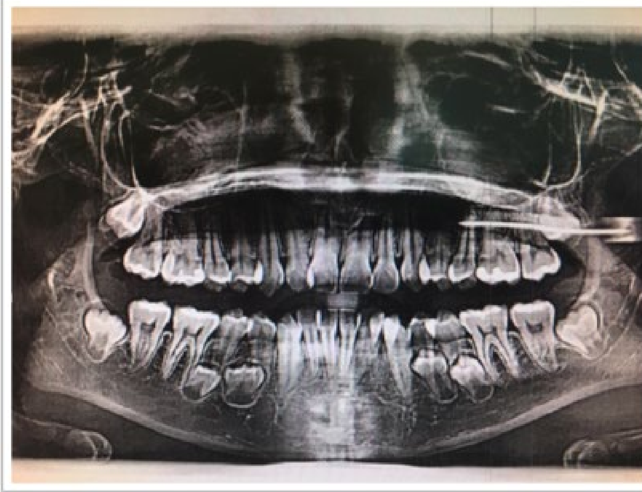
Root Destruction



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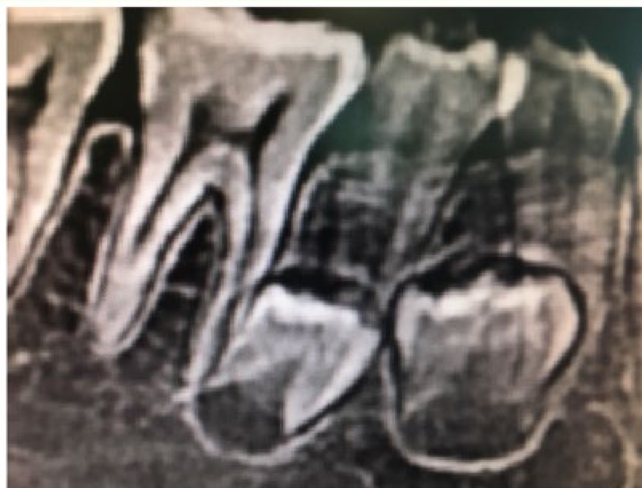
Root Destruction



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Case Submission

HLD Index score sheet must be completed by an orthodontist who is a graduate of an ADA accredited orthodontic residency/program.

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1. Cleft Palate Deformity

- Automatic qualification
- If the deformity cannot be demonstrated on the diagnostic casts, the condition must be diagnosed by properly credentialed experts and that diagnosis must be supported by an attached description.
- If present, enter an "X" and score no further.

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2. Cranio-facial Anomaly

- Automatic qualification
- Attach description of condition from a credentialed specialist.
- Indicate an "X" and score no further.

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3. Deep Impinging Overbite

- Automatic qualification
- Tissue destruction of the palate must be clearly visible in the mouth.
- On the diagnostic casts, the lower teeth must be clearly touching the palate and tissue indentations, or evidence of soft tissue destruction must be clearly visible.
- Photographs are helpful in determining the presence of tissue damage
- Indicate an "X" and score no further.

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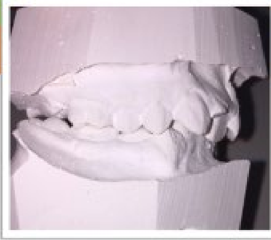
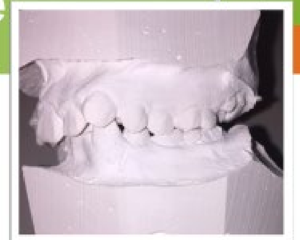
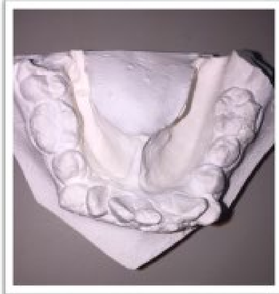
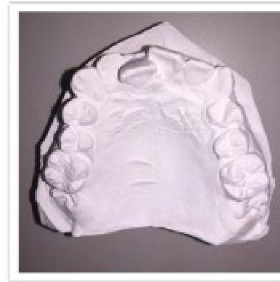
Deep Impinging Overbite

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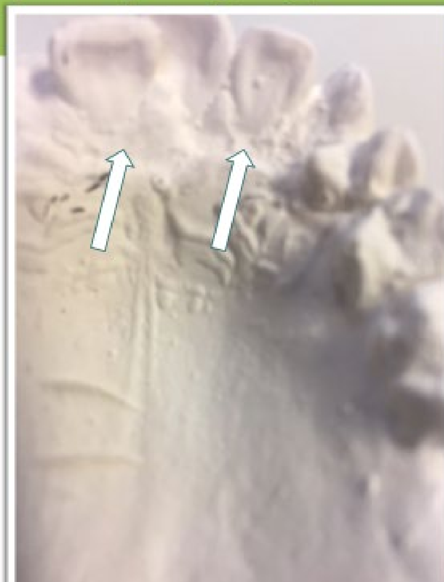
Deep Impinging Overbite



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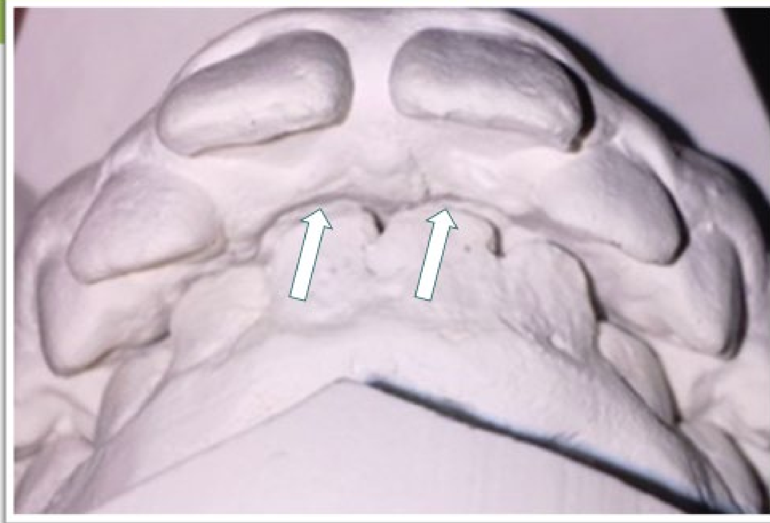
Deep Impinging Overbite



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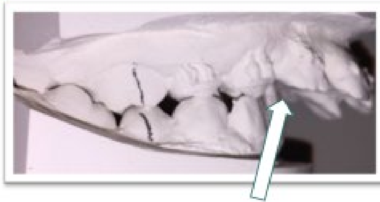
Deep Impinging Overbite



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4. Crossbite of Individual Anterior Teeth

- Automatic qualification
- Destruction of soft tissue must be clearly visible in the mouth with soft tissue loss reproducible and visible on the diagnostic casts.
- If present, enter an "X" and score no further.

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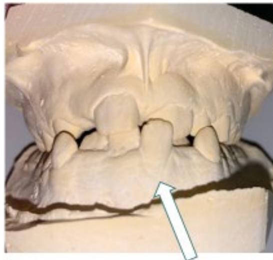
Anterior Crossbite



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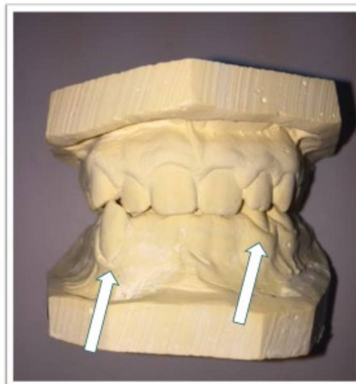
Attachment Loss



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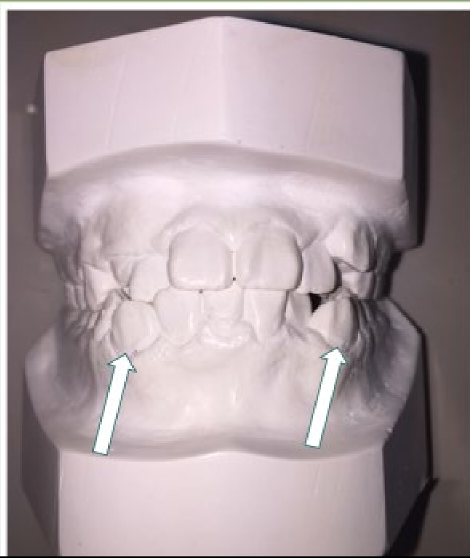
No Attachment Loss



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Attachment Loss NOT Caused by Anterior Crossbite

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5. Severe Traumatic Deviation

- Automatic qualification
- Examples: loss of premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.
- Attach documentation and description of condition.
- If present, enter an "X" and score no further.

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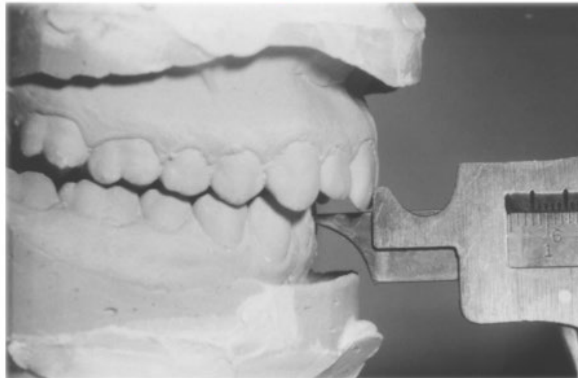
6A. Overjet greater than 9mm with incompetent lips or Mandibular Protrusion greater than 3.5mm with masticatory and speech difficulties



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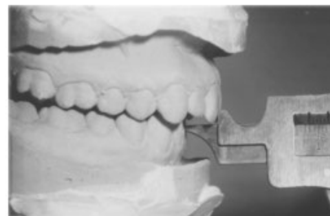
6A. Overjet greater than 9mm…

- 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 its corresponding lower central or lateral incisor.



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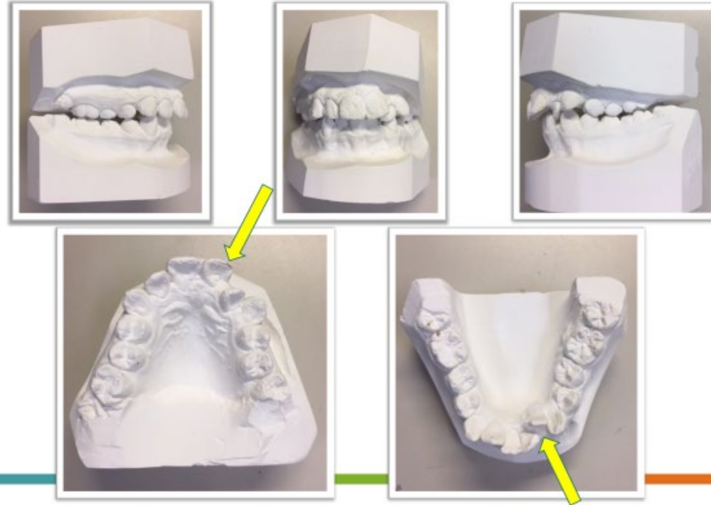
Overjet



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6A. Overjet greater than 9mm…

- Automatic qualification
- If present, enter an "X" and score no further.

The remaining conditions must score 26 or more to qualify.

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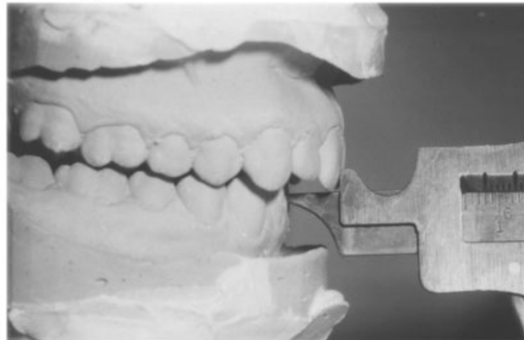
6B. Overjet equal to or less than 9mm

- Do not use the upper lateral incisors or cuspids



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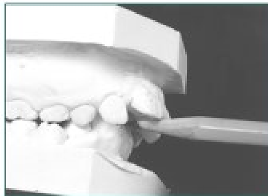
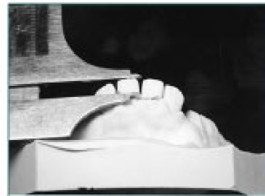
7. Overbite in mm

- Hold a pencil parallel to the occlusal plane and use the incisal edge of one of the upper central incisors to place a pencil mark indicating the extent of overlap.
- The measurement is done on the lower incisor from the incisal edge to the pencil mark.





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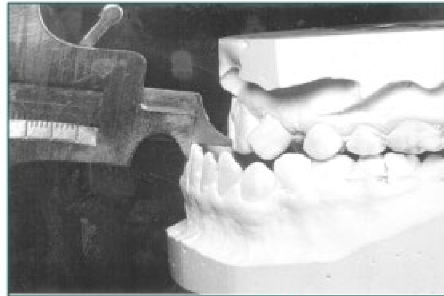
8. Mandibular Protrusion equal to or less than 3.5mm

- Measured from the labial surface of a lower incisor parallel to the occlusal plane and perpendicular to the labial surface of an upper central incisor.
- The measurement in millimeters is entered on the score sheet and multiplied by five.



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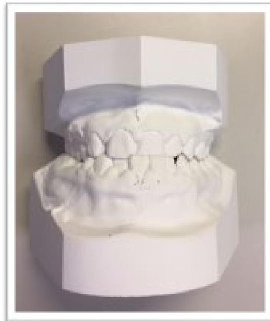
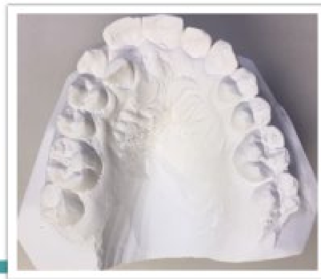
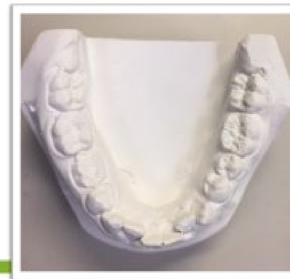
Mandibular Protrusion







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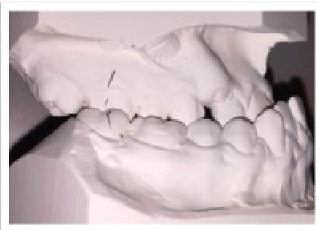
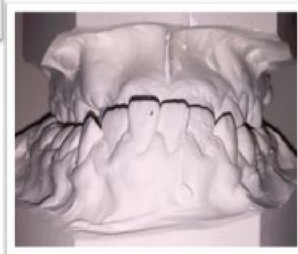
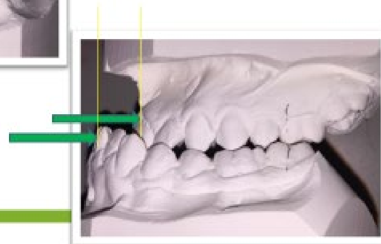
Mandibular Protrusion







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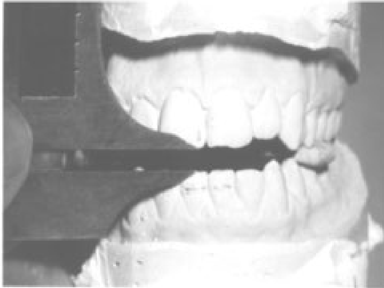
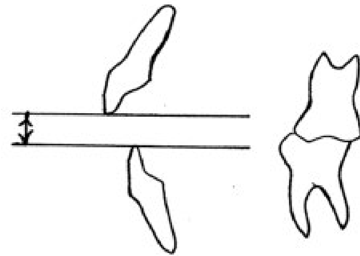
9. Open bite in mm

- Measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor.
- In some situations, one has to make an approximation by measuring perpendicular to the occlusal plane.





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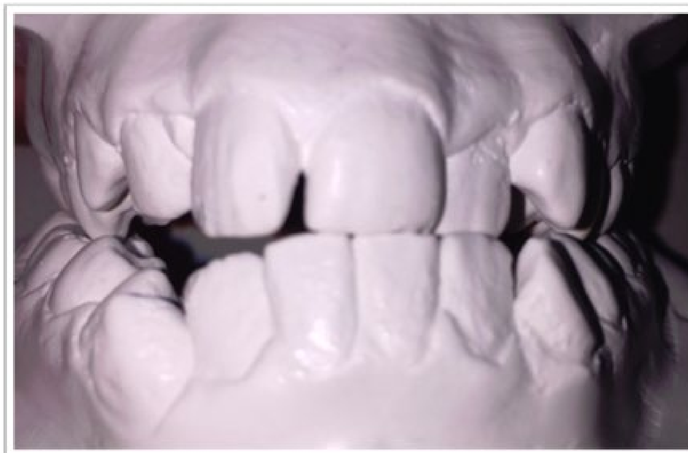
Anterior Open Bite



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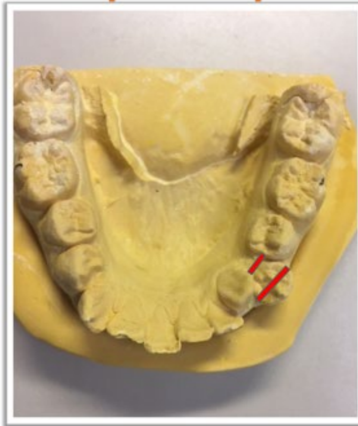
10. Ectopic Eruption

- Identify the tooth/teeth by number/s
- Count each tooth excluding third molars
- Enter the number of teeth on the score sheet and multiply by three.
- If anterior crowding is present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition.

B-PRL-TRN-013.W

Ectopic Eruption



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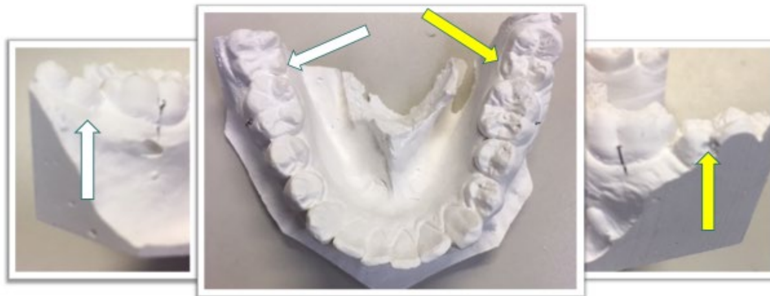
Ectopic Eruption of Second Molars



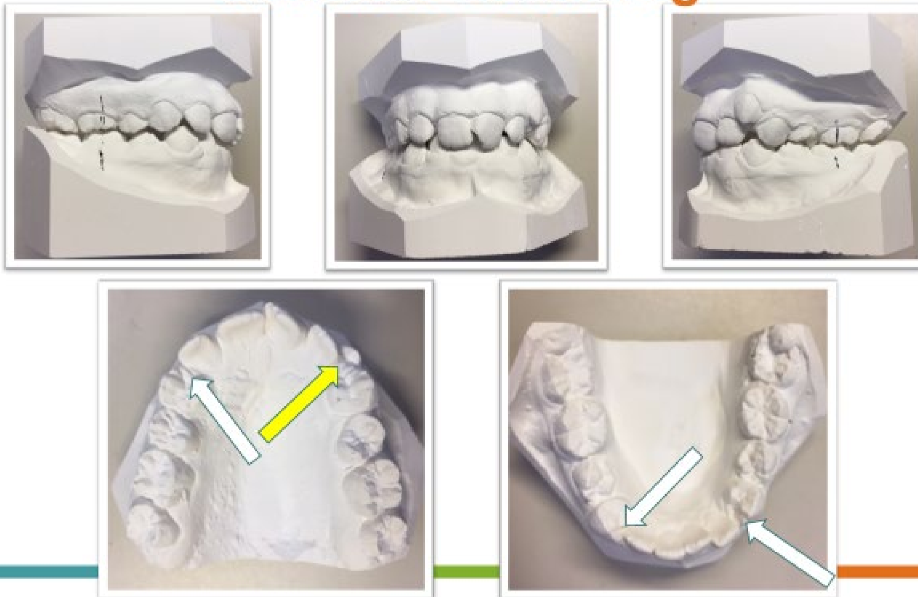
B-PRL-TRN-013.W

11. Anterior Crowding

- Anterior arch length insufficiency must exceed 3.5 mm
- Enter five points for a maxillary arch with anterior crowding and five points for a mandibular arch with anterior crowding.
- If ectopic eruption is also present in the anterior portion of the mouth, score only the most severe condition.

B-PRL-TRN-013.W

Anterior Crowding



B-PRL-TRN-013.W

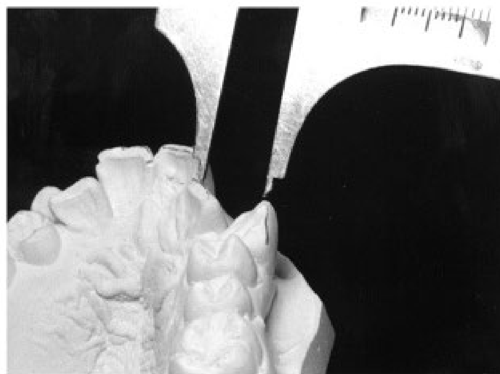
12. Labio-Lingual Spread in mm

- Use a Boley gauge 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 the tooth to a line representing the normal arch line.

B-PRL-TRN-013.W

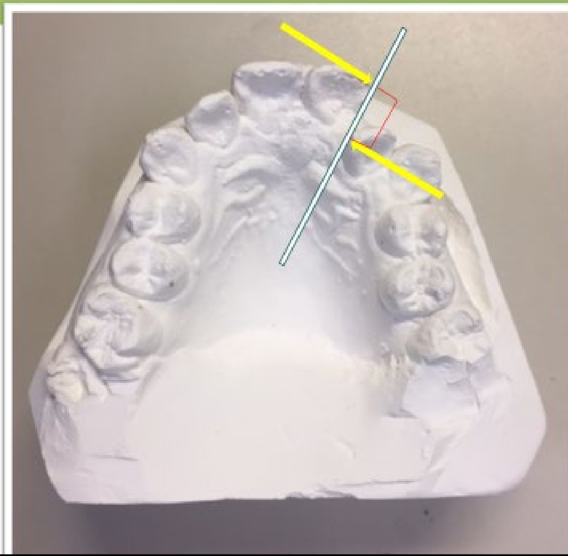
12. Labio-Lingual Spread in mm

- Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured.



B-PRL-TRN-013.W

Labio-Lingual Measurement



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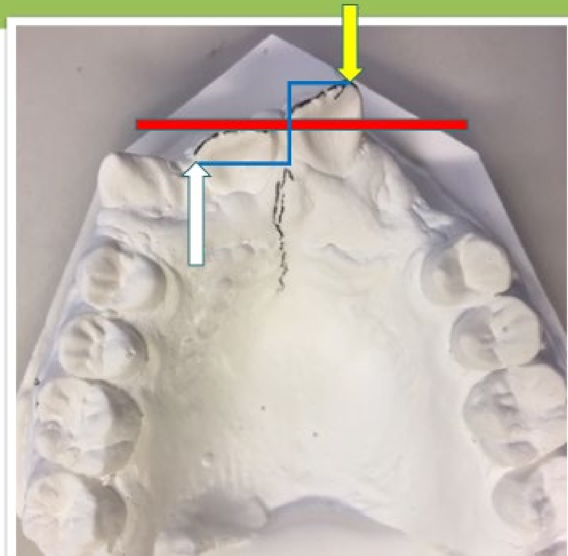
Labio-Lingual Measurement



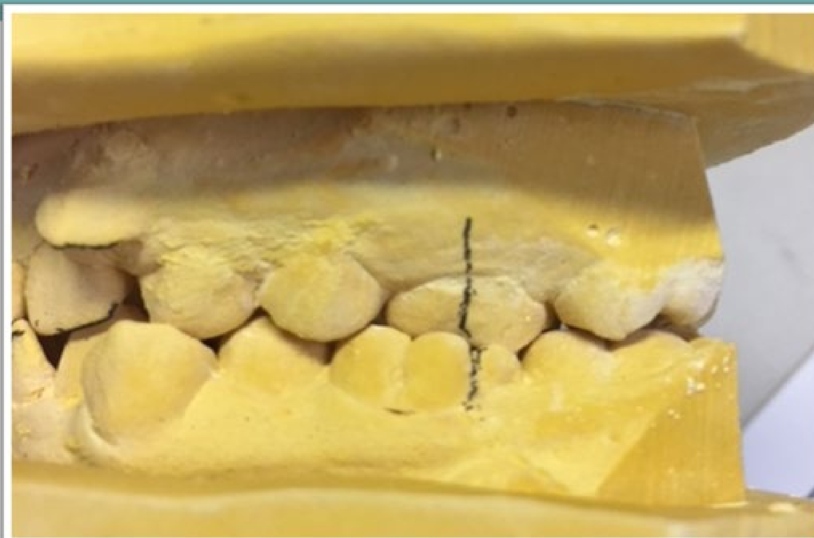
B-PRL-TRN-013.W

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 two 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 on the score sheet.
- Bilateral posterior crossbite scores as zero.

B-PRL-TRN-013.W

Unilateral Posterior Crossbite



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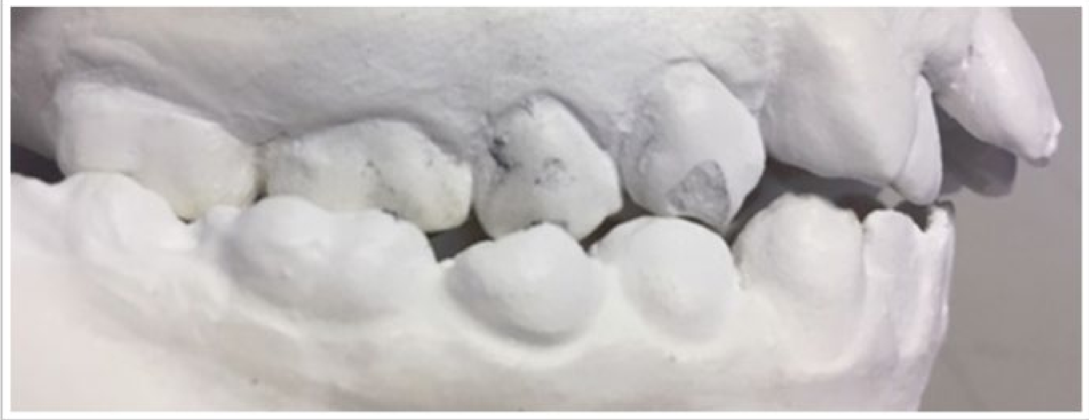
Unilateral Posterior Crossbite



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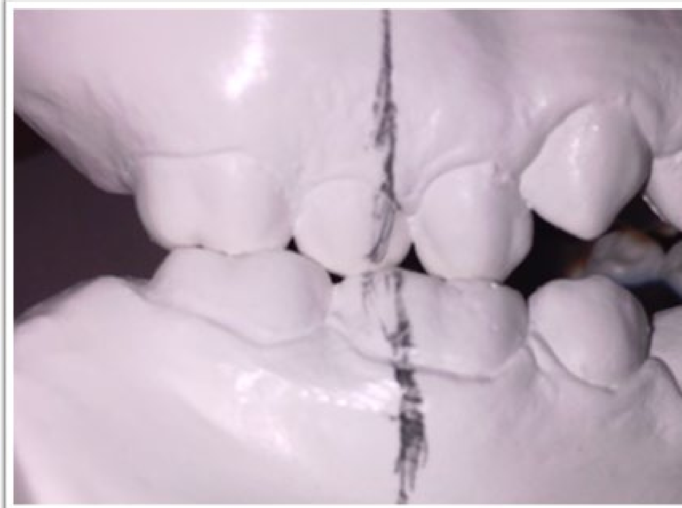
Unilateral Posterior Crossbite

B-PRL-TRN-013.W

Unilateral Posterior Crossbite



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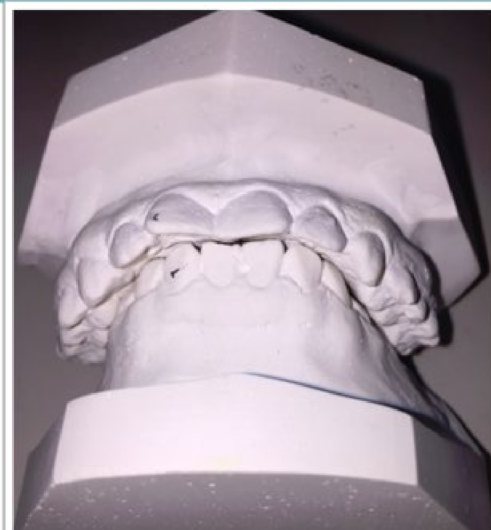
Bilateral Posterior Crossbite



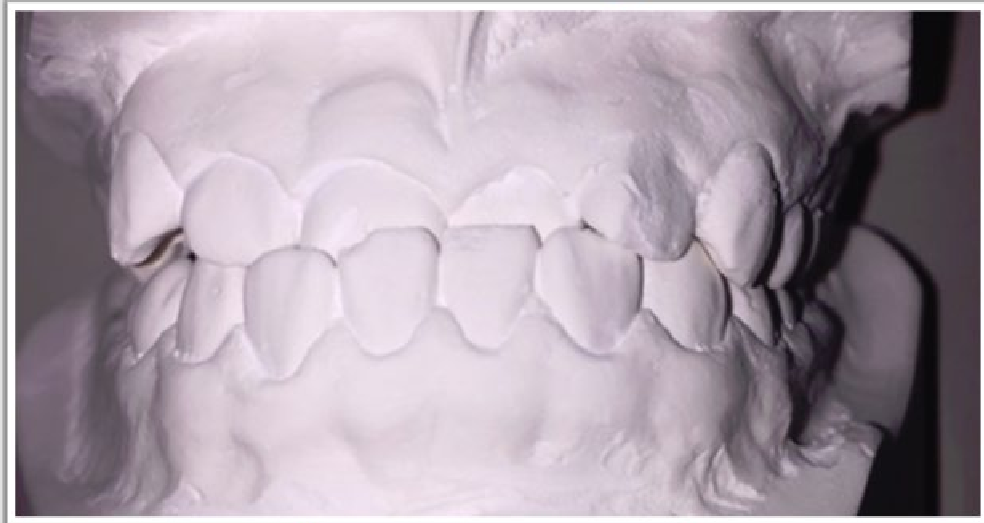
B-PRL-TRN-013.W

Labeling models

- Diagnostic casts must be properly labeled on each cast (upper and lower)
  - ➢ Patient's first and last name
  - ➢ Medi-Cal Identification Number
  - ➢ Billing Provider Name
  - ➢ Billing Provider NPI

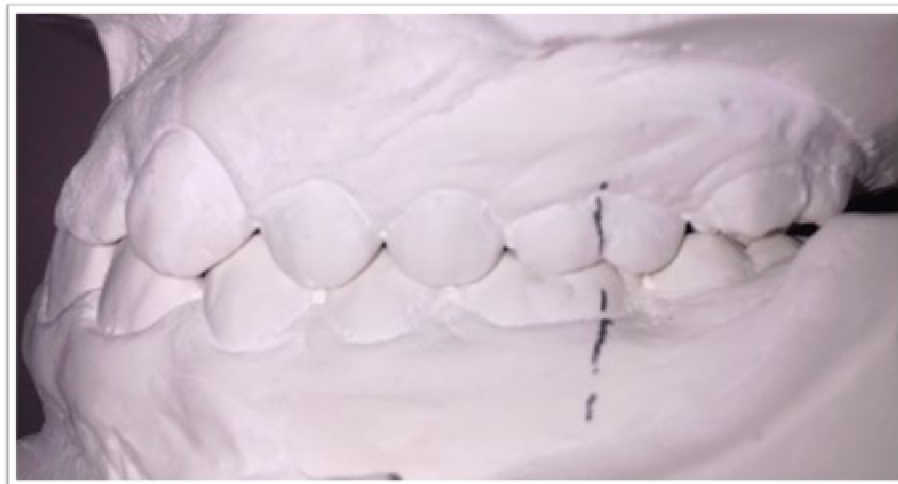
B-PRL-TRN-013.W

Case Study



B-PRL-TRN-013.W

Case Study



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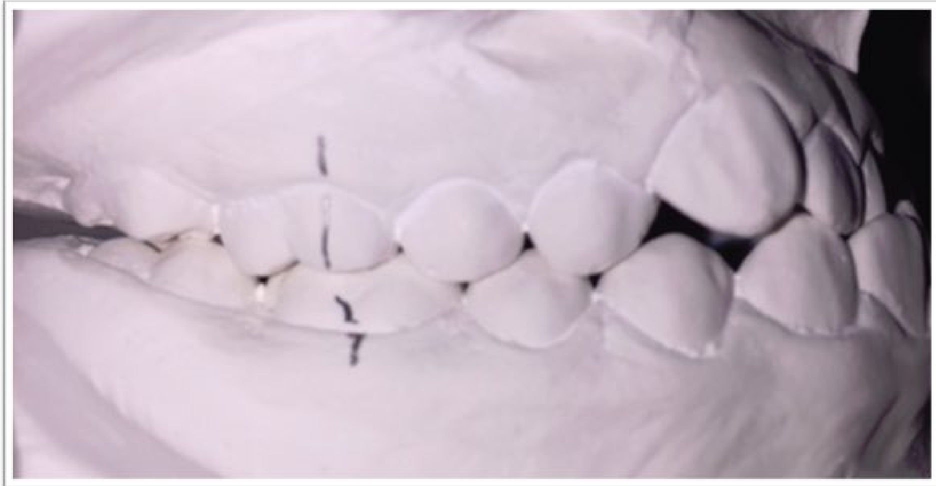
Case Study



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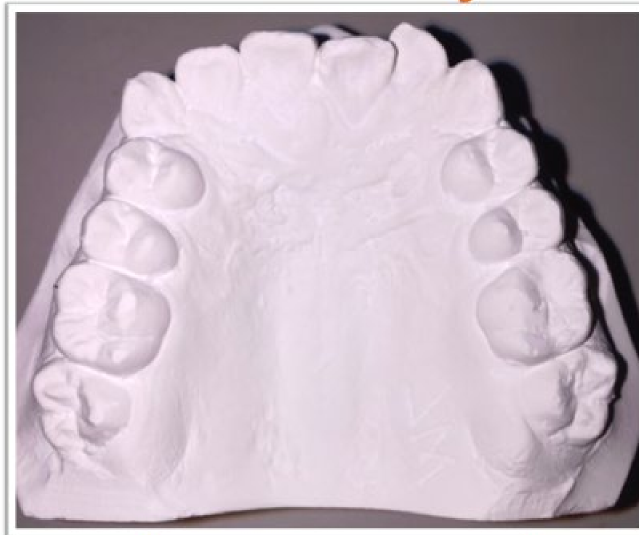
Case Study



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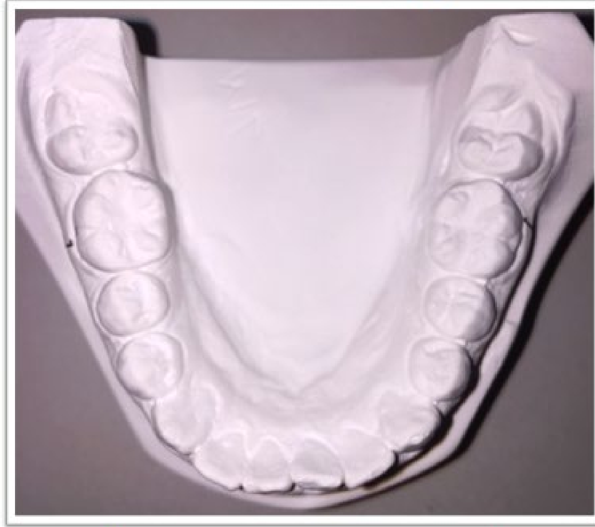
Case Study



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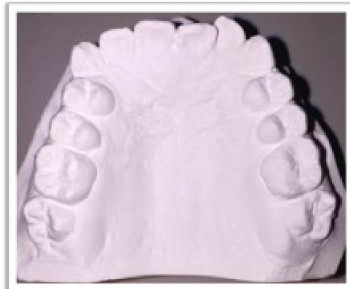
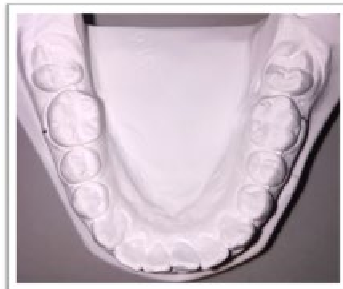
Case Study





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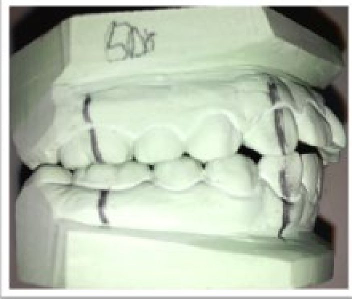
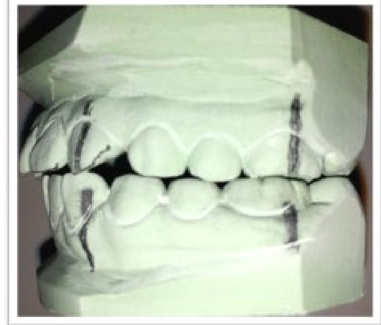
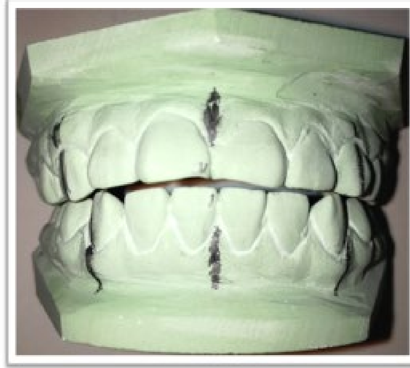


Case Study





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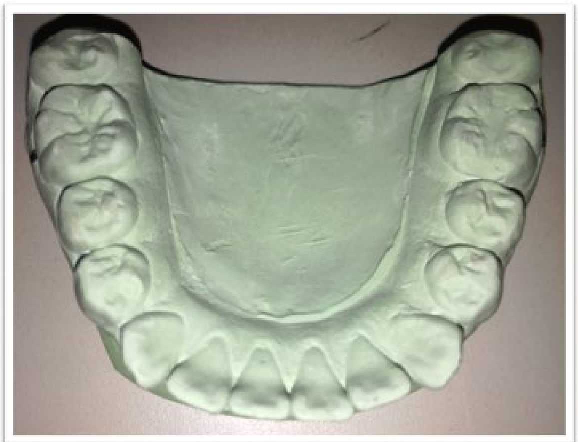
Case Study



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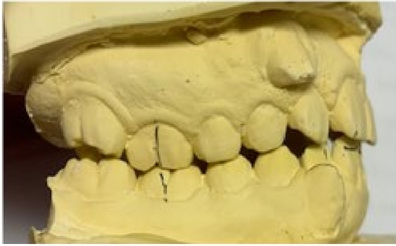
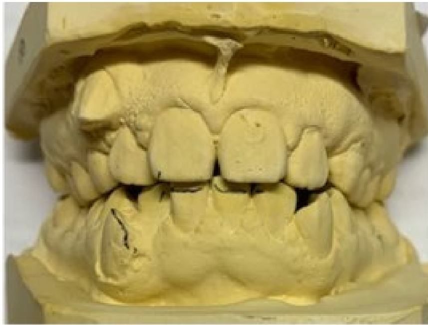
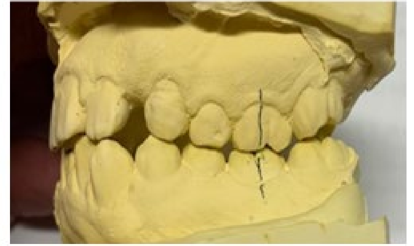
Case Study







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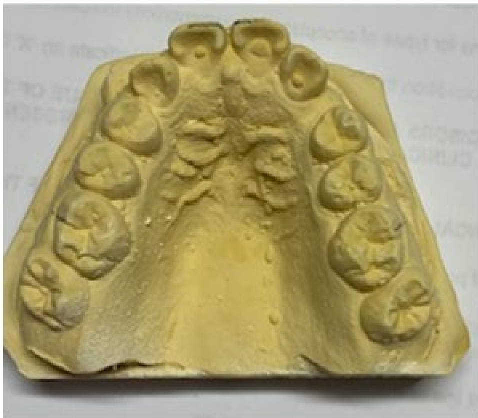
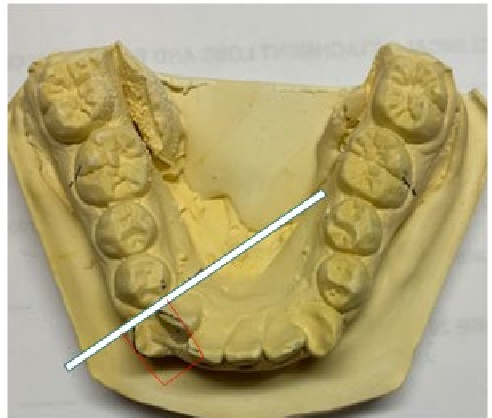
Case Study





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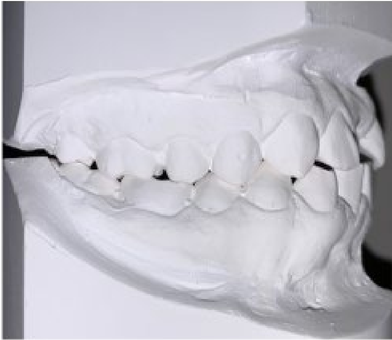
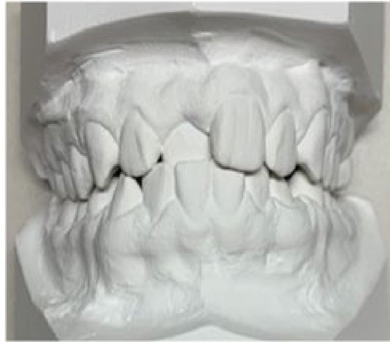
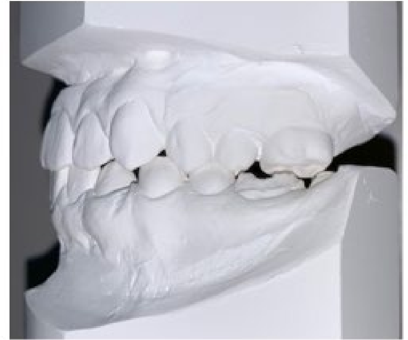
Case Study







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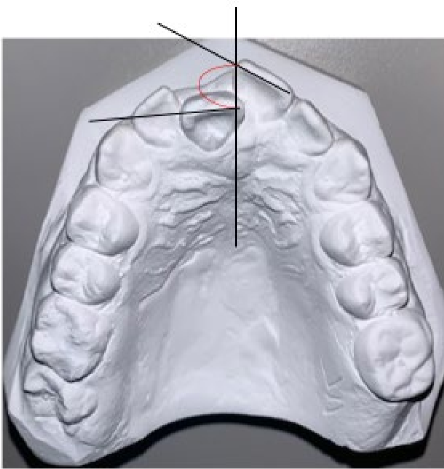
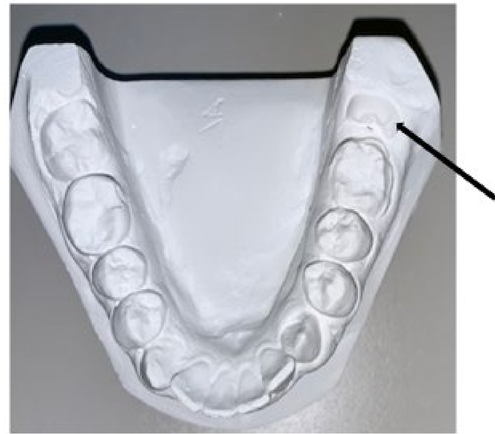
Case Study





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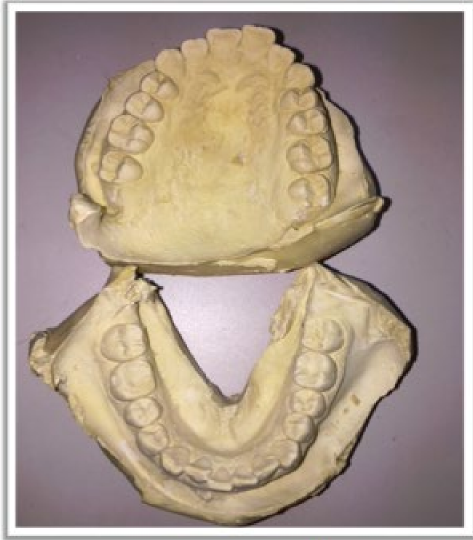
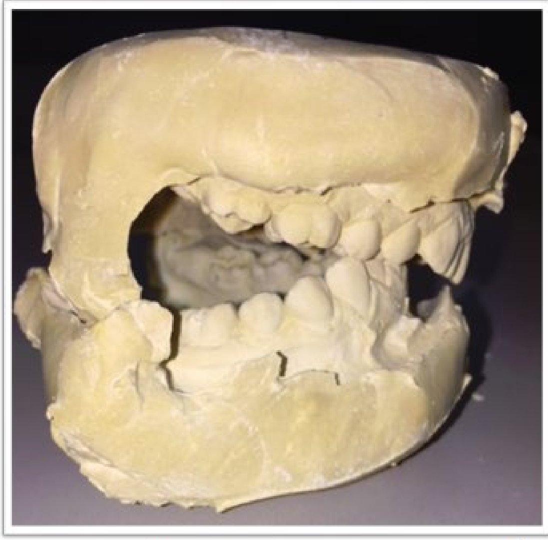
Model Trimmer

B-PRL-TRN-013.W

Model Trimmer





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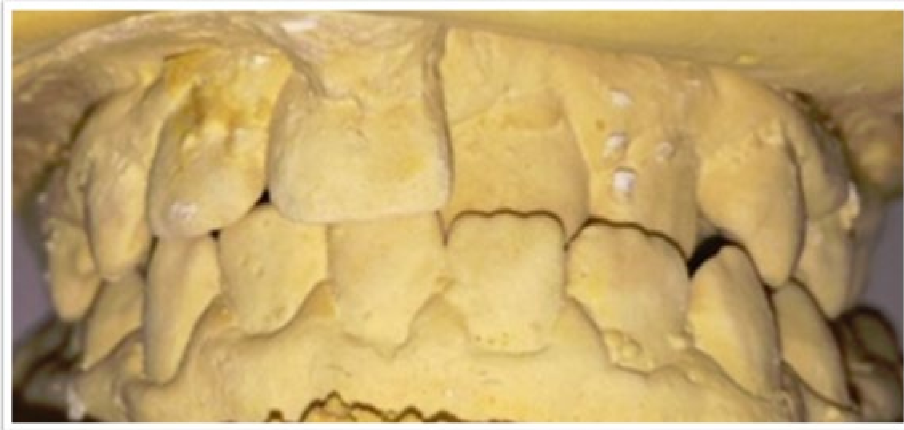
Remove Artifacts



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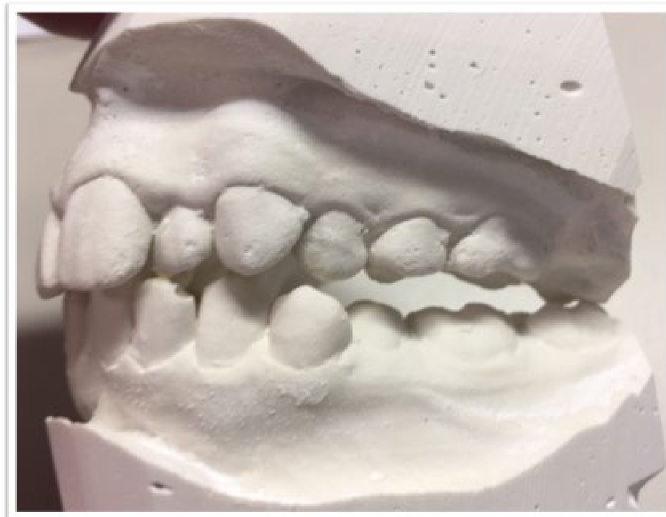
Casts Must Articulate



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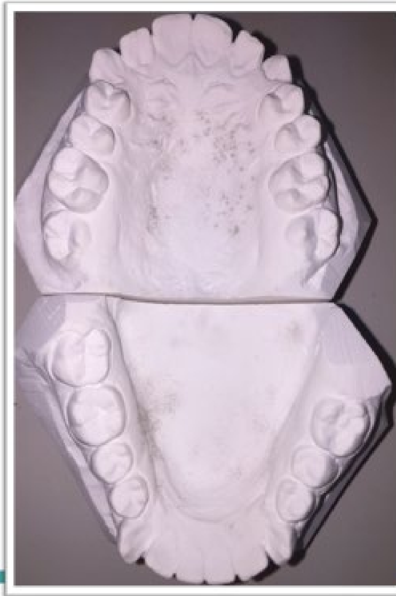
Allow Casts to Dry



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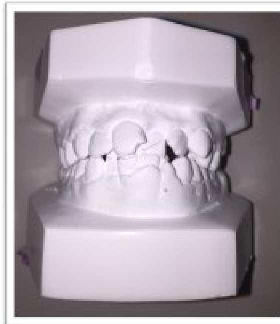
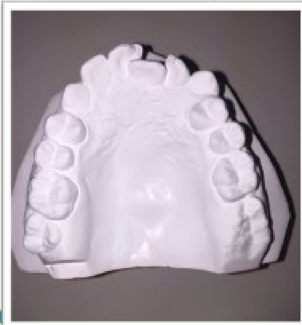
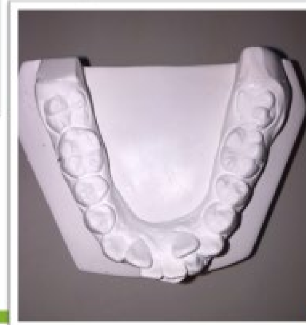
No Artifacts







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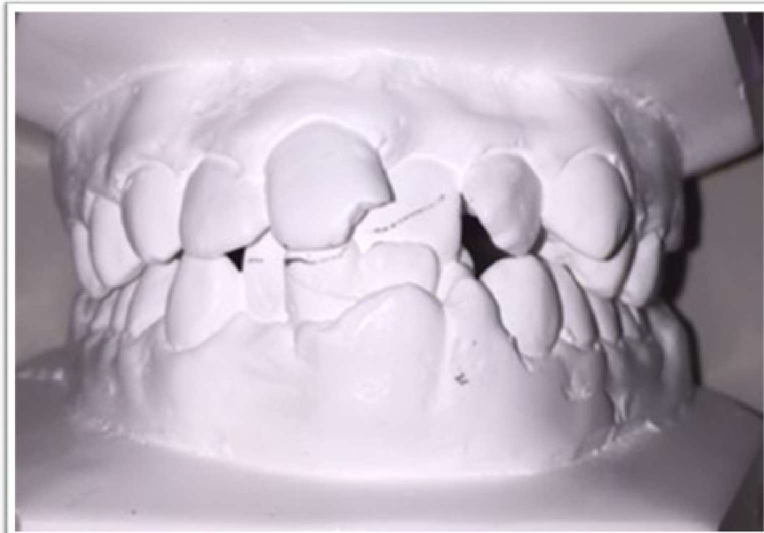

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Wax Bites

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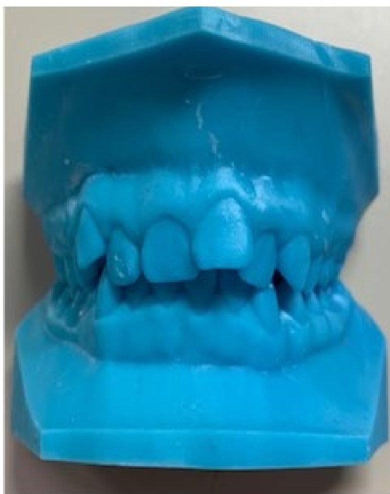
Printed Casts



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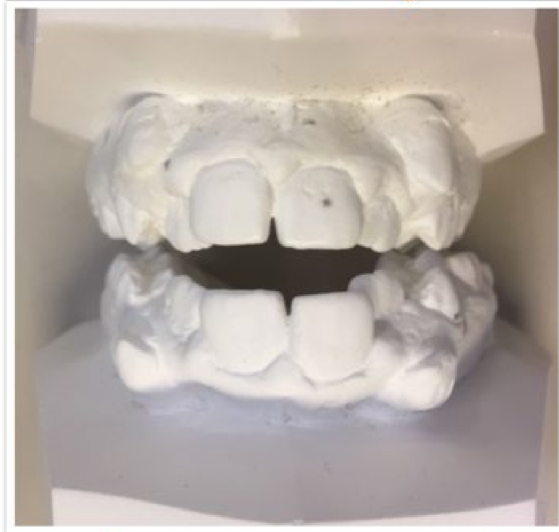
Efficiency



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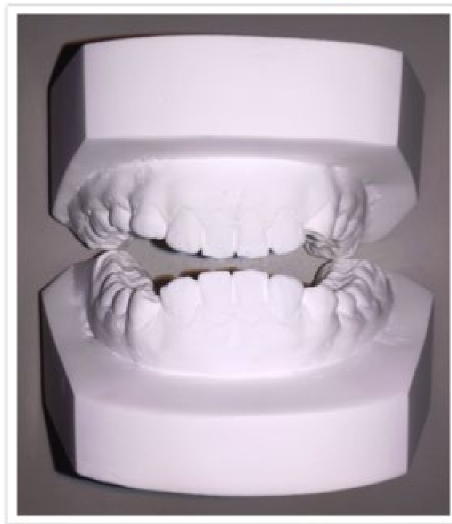
Efficiency



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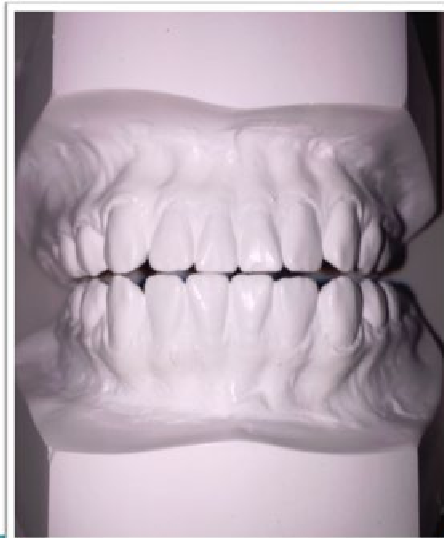
Efficiency

B-PRL-TRN-013.W

Efficiency



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Diagnostic Casts

Diagnostic Casts (Procedure D0470) are required documentation for all handicapping malocclusion and cleft palate treatment plan requests. Exception: If the member has a cleft palate that is not visible on diagnostic casts, casts are not required. However, photographs or documentation from a credentialed specialist must be submitted.

Cranio-facial 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. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

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 member's name, Client Index Number (CIN) or Benefits Identification Card (BIC) number, the billing provider's name, and billing provider's NPI. If the casts are received without identification, they will be destroyed.

Careful packaging will help ensure that the casts arrive at the Medi-Cal Dental program in good condition. The Medi-Cal Dental 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.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for payment or the TAR for orthodontic treatment.

Only duplicate or second pour diagnostic casts should be sent to the Medi-Cal Dental. The casts will not be returned. Diagnostic casts of denied cases will be kept in the Medi-Cal Dental office for 30 days following a denial and up to one year off-site to enable a request for reevaluation.

The 2nd Step…

- If the member qualifies for orthodontia under the guidelines of the Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet, you may provide the next step;

D0470 = Diagnostic Casts

B-PRL-TRN-013.W

Orthodontic Program Diagnostic Casts

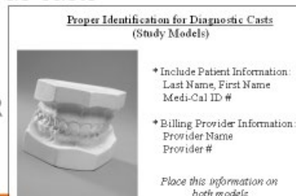
1. Are a benefit once for each phase of orthodontic treatment
2. Will not be returned by the Medi-Cal Dental program
3. Are payable only upon authorization of the orthodontic treatment plan

B-PRL-TRN-013.W

Orthodontic Program Diagnostic Casts

Submit Casts:

- That are properly trimmed and free of voids
- Be sure to mark centric, and send a bite registration or indicate markings of occlusion
- Label both upper and lower casts clearly with patient and billing provider information
- Do not send Treatment Authorization Request (TAR) or Resubmission Turnaround Document (RTD) in the same package as casts
- Send only clean, dry casts
- Pack casts carefully
- Send casts approximately 10 days earlier than TAR



B-PRL-TRN-013.W

DO NOT WRITE IN THIS AREA

YY 018 1 00003

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507

1. PATIENT NAME (LAST,FIRST,M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	F: x	mm dd yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address	00000	

Item	Question	YES
9.	CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?________	
10.	OTHER ATTACHMENTS?	
11.	CHECK IF ACCIDENT/INJURY?	
	EMPLOYMENT RELATED?	
12.	ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	
13.	CHECK IF OTHER DENTAL COVERAGE:	
14.	MEDICARE DENTAL COVERAGE:	
15.	RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	
16.	CHECK IF CHDP CHILD HEALTH AND DISABILITY PREVENTION?	
17.	CCS CALIFORNIA CHILDREN SERVICES?	
18.	MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	x

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.)	20. BILLING PROVIDER NPI
Adams, James DDS	1234567891

21. MAILING ADDRESS	TELEPHONE NUMBER
30 Center Street	xxx xxx-xxxx

CITY, STATE	ZIP CODE
Anytown, CA	95814

BIC Issue Date: MM DD YY

EVC #: C1294B1539

22. PLACE OF SERVICE

OFFICE 1	HOME 2	CLINIC 3	SNF 4	ICF 5	HOSPITAL IN-PATIENT 6	HOSPITAL OUT-PATIENT 7	OTHER (PLEASE SPECIFY) 8
x							

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Limited Oral Evaluation	MM DD YY		D0140	50.00	1234567899
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED	50.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	MM DD YY

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 Mary Smith
SIGNATURE

MM DD YY
DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTICE:
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.

DC-217 (R 10/19)

The 3rd Step…

1. Submit a claim for the exam
2. Complete a TAR for the full orthodontic treatment plan
3. Attach the HLD Index Score Sheet to the TAR
4. Send claim and TAR together in the document mailing envelope
5. Send properly packed diagnostic casts separately

B-PRL-TRN-013.W

Treatment Plan Authorization

The Treatment Authorization Request (TAR) for orthodontic services must include the complete orthodontic treatment plan: Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080), Periodic Orthodontic Treatment Visits (Procedure D8670), and Orthodontic Retention (Procedure D8680). Note: Cranio-facial anomalies cases may request Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6).

Include with the authorization request any necessary radiographs, such as a full mouth series (Procedure D0210) or panoramic film (Procedure D0330), and cephalometric head film and tracings (Procedure D0340). Indicate in the "quantity" field of the TAR form, the number of visits for active treatment (Procedure D8670) depending on the type of case and the phase of dentition. Also, indicate the “case type” and “phase of dentition” in the comments section (box 34). Use usual, customary, and reasonable (UCR) fees times the quantity to ensure accurate calculation of the Notice of Authorization (NOA.)

Attach the HLD Score Sheet to the TAR and send it to the address printed on the form. Diagnostic Casts should be properly packed and boxed and sent separately to the same address. Sending the casts approximately five days prior to sending the TAR will insure more expeditious handling at Medi-Cal Dental. Submission of the HLD Score Sheet and diagnostic casts (or documentation from a credentialed specialist) are required documentation to substantiate the treatment plan request.

The Medi-Cal Dental orthodontic consultant will evaluate the HLD Score Sheet and diagnostic casts or documentation together, to determine if the case qualifies for treatment under the Medi-Cal Dental guidelines for orthodontic services.

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.): Last, First
3. SEX M F: X
4. PATIENT BIRTHDATE MO DAY YR: mm dd yy
5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999

6. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER

CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI

9. CHECK IF RADIOGRAPHS ATTACHED? YES — HOW MANY?____________
10. OTHER ATTACHMENTS? YES: X
11. CHECK IF ACCIDENT/INJURY? YES — EMPLOYMENT RELATED? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
13. CHECK IF OTHER DENTAL COVERAGE: YES
14. MEDICARE DENTAL COVERAGE: YES
15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
17. CCS CALIFORNIA CHILDREN SERVICES? YES
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES: X

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.): Adams, James, DDS Inc.
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: xxx xxx-xxxx
CITY, STATE: Anytown, CA
ZIP CODE: 95814

BIC Issue Date

Supporting documentation from a credentialed specialist may be substituted when Diag. Casts do not verify the condition for cleft palate or cranio-facial anomalies cases.

22. PLACE OF SERVICE: OFFICE 1 (X) | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE PERFORMED	QUANTITY	PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Comprehensive Ortho Tx.			D8080	500.00	
		2 Periodic Ortho Tx Visits		08	D8670	1920.00	
U		3 Ortho Retention		01	D8680	500.00	
L		4 Ortho Retention		01	D8680	500.00	
		5 Full Mouth Series			D0210	75.00	
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

CASE TYPE: Malocclusion - Permanent Dentition

HLD Score Sheet Attached / Diagnostic Casts Sent Separately

35. TOTAL FEE CHARGED: 3495.00
36. PATIENT SHARE-OF-COST AMOUNT:
37. OTHER COVERAGE AMOUNT:
38. DATE BILLED: MM DD YY

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 Mary Smith — SIGNATURE
MM DD YY — DATE

IMPORTANT NOTICE:
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.

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

Reevaluation of the Notice of Authorization (NOA)

Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Medi-Cal Dental on or before the expiration date (within 180 days).

Re-evaluation

- May be requested on a denied NOA for the Orthodontic Treatment Plan only
- Check the 'Reevaluation Box'
- Must be received by Medi-Cal Dental on or before the 'expiration date'
- Do submit HLD/additional documentation
- Do not sign the NOA
- NOA may only be submitted for reevaluation 'one time'

B-PRL-TRN-013.W

There are no reevaluations on "exploded" NOAs. An explanation of the term "exploded" NOAs is as follows: The TAR will include all requested orthodontic treatments, but when Medi-Cal Dental sends the NOAs, they will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- The first NOA will include the Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080) along with any radiographs that were requested on the original TAR.

- The remaining Treatment Visit NOAs (Procedure D8670) will be sent once per quarter, over the course of treatment.

- Then the orthodontic retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment.

DO NOT WRITE IN THIS AREA

YY091100730

TICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY
TO: 05/06/YY

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

RE-EVALUATION IS REQUESTED ☐ YES

PAGE___OF_____

1. BENEFICIARY NAME (LAST, FRIST, M.I.)	3. SEX M F	4. BENEFICIARY BIRTHDATE MO DAY YR	5. BENEFICIARY MEDI-CAL I.D. NO.
Last, First	x (F)	mm dd yy	99999999999999

9. RADIOGRAPHS ATTACHED? HOW MANY? ________ CHECK IF YES	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? CHECK IF YES; EMPLOYMENT RELATED? YES	13. OTHER DENTAL COVERAGE? CHECK IF YES; 16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS — 1234567891
30 Center Street — (xxx) xxx-xxxx
Anytown, CA — 95814

23.
BIC Issue Date: ________________
EVC #: ________________

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SUR-FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1 COMPRE ORTHO-ADOLESCENT		01	D8080	975.00	750.00		
			2 FULL MOUTH SERIES		01	D0210	75.00	40.00		
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	1050.00
46. TOTAL ALLOWANCE	790.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

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 MEDII-CAL DENTAL– 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.

The 4th Step

- Submit a claim for diagnostic casts

DO NOT WRITE IN THIS AREA

YY 118 1 00003

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.): Last, First
3. SEX: M F — x
4. PATIENT BIRTHDATE: MO mm DAY dd YR yy
5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999
6. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER
CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI

9. RADIOGRAPHS ATTACHED? CHECK IF YES
HOW MANY?___________
10. OTHER ATTACHMENTS? YES
11. ACCIDENT/INJURY? CHECK IF YES
EMPLOYMENT RELATED? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
13. OTHER DENTAL COVERAGE: CHECK IF YES
14. MEDICARE DENTAL COVERAGE: YES
15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
17. CCS CALIFORNIA CHILDREN SERVICES? YES
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES — X

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.): Adams, James DDS
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: xxx xxx-xxxx
CITY, STATE: Anytown, CA
ZIP CODE: 95814

BIC Issue Date: MM DD YY

EVC #: C1294B1539

22. PLACE OF SERVICE: OFFICE 1 (x) | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Diagnostic Casts	MM DD YY		D0470	90.00	1234567899
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

35. TOTAL FEE CHARGED: 90.00
36. PATIENT SHARE-OF-COST AMOUNT:
37. OTHER COVERAGE AMOUNT:
38. DATE BILLED: MM DD YY

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 Mary Smith — SIGNATURE
MM DD YY — DATE

IMPORTANT NOTICE:
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.

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

Orthodontic Treatment Procedures

Payment for Procedure D8670 will be made once per calendar quarter per provider for the active phase of orthodontic treatment. A calendar quarter is defined as: January – March, April – June, July – September, and October – December. Submit one NOA containing *only one* date of service for each quarter of treatment (regardless of the number of actual treatment visits within that quarter.) Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080.)

The active phase of orthodontic treatment will be authorized for a set number of visits depending on the case type. Some treatment plans may take longer than originally anticipated due to the severity of the case. It is possible to request additional quarterly treatment visits. The request for additional treatment will require submission of a new TAR requesting; any visits left to be completed from the original authorization, plus additional visits that will complete the case, plus the retainers. If there are any outstanding NOAs from the original authorization, please attach them to the new TAR and request that they be deleted. Written documentation to justify the need for additional orthodontic treatment and progress photos must be submitted with the new TAR.

When the new TAR is authorized by Medi-Cal Dental, a series of NOAs confirming the authorization will be mailed. The NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. Use the *new* NOAs for billing purposes. Each quarter when services are provided, submit one NOA to Medi-Cal Dental for payment. Bill only one adjustment per NOA. Before submitting the NOA to Medi-Cal Dental, indicate the date of service and sign the NOA.

If orthodontic treatment should be accomplished in less time than originally authorized, document this on the NOA for retainers and attach a progress photo when submitting for payment. Attach any unused NOAs for quarterly visits marking them for deletion.

Time limitations for payment of NOAs are as follows:

- 100% of the Schedule of Maximum Allowances (SMA), when received no later than 6 months from the end of the month in which the service was performed.
- 75% of the SMA when received no later than 7 to 9 months from the end of the month in which the service was performed.
- 50% of the SMA when received no later than 10 to 12 months from the end of the month in which the service was performed

Notices of Authorization for payment will be processed in accordance with general Medi-Cal Dental billing policies and criteria requirements for orthodontic services. **Please remember that authorization does not guarantee payment. Payment is always subject to member's eligibility.**

Exploded NOAs from Medi-Cal Dental

DO NOT WRITE IN THIS AREA

YY126170013

NOTICE OF AUTHORIZATION

DHCS Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

AUTHORIZATION FOR SERVICE BELOW IS:
FROM: 05/06/YY
TO: 05/06/YY

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, M.I.): Last, First
3. SEX M F: x
4. BENEFICIARY BIRTHDATE MO DAY YR: mm dd yy
5. BENEFICIARY MEDI-CAL I.D. NO.: 99999999999999

9. RADIOGRAPHS ATTACHED? HOW MANY? ______ CHECK IF YES
10. OTHER ATTACHMENTS? CHECK IF YES
11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? CHECK IF YES
16. CHDP YES
7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23.
BIC Issue Date: ________________
EVC #: ______________________

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1 COMPRE ORTHO-ADOLESCENT		01	D8080	975.00	750.00		
			2 FULL MOUTH SERIES		01	D0210	75.00	40.00		
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			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED
45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED: 1050.00
46. TOTAL ALLOWANCE: 790.00
36. BENEFICIARY SHARE-OF-COST AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED

34. COMMENTS

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.

DO NOT WRITE IN THIS AREA

YY127170001

NOTICE OF AUTHORIZATION

DHCS Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

AUTHORIZATION FOR SERVICE BELOW IS:
FROM: 05/06/YY
TO: 05/06/YY

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, M.I.): Last, First
3. SEX M F: x
4. BENEFICIARY BIRTHDATE MO DAY YR: mm dd yy
5. BENEFICIARY MEDI-CAL I.D. NO.: 99999999999999

9. RADIOGRAPHS ATTACHED? HOW MANY? ______ CHECK IF YES
10. OTHER ATTACHMENTS? CHECK IF YES
11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? CHECK IF YES
16. CHDP YES
7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23.
BIC Issue Date: mm/dd/yy
EVC #:

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1 PERIODIC ORTHO TRMT VISIT		01	D8670	300.00	210.00		1234567899
			2							
			3							
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			11							
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			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED
45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED: 300.00
46. TOTAL ALLOWANCE: 210.00
36. BENEFICIARY SHARE-OF-COST AMOUNT
37. OTHER COVERAGE AMOUNT
38. DATE BILLED

34. COMMENTS

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.

DO NOT WRITE IN THIS AREA

YY220170001

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 05/06/YY

TO: 05/06/YY

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF_____

1. BENEFICIARY NAME (LAST, FRIST, M.I.): Last, First

3. SEX M F: x

4. BENEFICIARY BIRTHDATE MO DAY YR: mm dd yy

5. BENEFICIARY MEDI-CAL I.D. NO.: 99999999999999

9. RADIOGRAPHS ATTACHED? HOW MANY? ________ CHECK IF YES

10. OTHER ATTACHMENTS? CHECK IF YES

11. ACCIDENT / INJURY? CHECK IF YES — EMPLOYMENT RELATED? YES

13. OTHER DENTAL COVERAGE? CHECK IF YES

16. CHDP YES

7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23. BIC Issue Date: MM DD YY
EVC #: xxxxxxxxxx

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SUR-FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1 PERIODIC ORTHO TRMT VISIT	MM DD YY	01	D8670	300.00	210.00		1234567899
			2							
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED: 300.00

46. TOTAL ALLOWANCE: 210.00

36. BENEFICIARY SHARE-OF-COST AMOUNT

37. OTHER COVERAGE AMOUNT

38. DATE BILLED: mm dd yy

34. COMMENTS

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 Mary Jones — ORIGINAL SIGNATURE REQUIRED — MM DD YY 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.

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.): Last, First
3. SEX: M F x
4. PATIENT BIRTHDATE MO DAY YR: mm dd yy
5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999
6. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER
CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI

9. CHECK IF RADIOGRAPHS ATTACHED? YES HOW MANY?______
10. OTHER ATTACHMENTS? YES
11. CHECK IF ACCIDENT/INJURY? YES EMPLOYMENT RELATED? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
13. CHECK IF OTHER DENTAL COVERAGE: YES
14. MEDICARE DENTAL COVERAGE: YES
15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
17. CCS CALIFORNIA CHILDREN SERVICES? YES
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES x

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.): Adams, James DDS
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: xxx xxx-xxxx
CITY, STATE: Anytown, CA
ZIP CODE: 95814
22. PLACE OF SERVICE: OFFICE 1 x | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

BIC Issue Date: ________________

EVC #: ____________________

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH,QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Periodic Ortho Treatment Visits		4	D8670	800.00	
U		2 Retainer			D8680	250.00	
L		3 Retainer			D8680	250.00	
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINE[D] ... PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NE[CESSARY] ... PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AN[Y] ... AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

x Mary Smith — SIGNATURE   MM DD YY — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY AB[OVE] ... STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

The TAR Form (for extension)

DO NOT WRITE IN THIS AREA

YY127170003

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:
FROM: 05/06/YY
TO: 05/06/YY

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

RE-EVALUATION IS REQUESTED ☐ YES

PAGE____OF____

1. BENEFICIARY NAME (LAST, FRIST, M.I.): Last, First
3. SEX: M F x
4. BENEFICIARY BIRTHDATE MO DAY YR: mm dd yy
5. BENEFICIARY MEDI-CAL I.D. NO.: 99999999999999

9. CHECK IF RADIOGRAPHS ATTACHED? YES HOW MANY? ______
10. CHECK IF OTHER ATTACHMENTS? YES
11. CHECK IF ACCIDENT / INJURY? YES EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? CHECK IF YES
16. CHDP YES
7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23.
BIC Issue Date: ________________
EVC #: ____________________

41. DELETE	26. TOOTH NO. LETTER ARCH	27. SUR-FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
X			1 PERIODIC ORTHO TRMT VISIT		01	D8670	300.00	210.00		
			2							
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED
45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	300.00
46. TOTAL ALLOWANCE	210.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

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 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 MEDI-CAL DENTAL – 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.

The NOA

(deleting old NOAs for new treatment plan)

D8696 = Repair Of Orthodontic Appliances-Maxillary
D8697 = Repair Of Orthodontic Appliances-Mandibular

- Does not require prior authorization except for transfer patients, which shall include photographs
- Requires an arch code
- The need must be documented with:
  - Type of appliance and a description of the repair
- A benefit once per appliance for patients under the age of 21
- Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires

B-PRL-TRN-013.W

D8698 = Re-Cement Or Re-Bond Fixed Retainer-Maxillary
D8699= Re-Cement Or Re-Bond Fixed Retainer-Mandibular

- This procedure does not require prior authorization
- Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
- Requires an arch code
- A benefit for patients under the age of 21 once per provider

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)

B-PRL-TRN-013.W

D8701 = Repair of Fixed Retainer, Includes Reattachment-Maxillary
D8702 = Repair of Fixed Retainer, Includes Reattachment-Mandibular

- This procedure does not require prior authorization except for transfer patients which shall include photographs.
- Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
- Requires an arch code.
- A benefit:
  - a. for patients under the age of 21.
  - b. once per appliance.
- Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

B-PRL-TRN-013.W

D8703 = Replacement Of Lost Or Broken Retainer-Maxillary
D8704 = Replacement Of Lost Or Broken Retainer-Mandibular

- This procedure does not require prior authorization except for transfer patients which shall include photographs
- Witten documentation for payment – indicate how the retainer was lost or why it is no longer serviceable
- Requires an arch code
- A benefit for patients under of 21, once per arch, only within 24 months following the date of service of orthodontic retention (D8680)

B-PRL-TRN-013.W

Transfer Cases

- Transferring from another Medi-Cal Dental provider:
  1. Submit new TAR for remaining treatment plan
  2. Attach letter from parent/legal guardian requesting deletion of previous provider's authorization

- Transferring from a Non Medi-Cal Dental provider:
  1. Submit new TAR for remaining treatment plan
  2. Send original diagnostic casts and progress photos, or
  3. Progress casts and current HLD Score Sheet

B-PRL-TRN-013.W

Billing Limitations

- You have one year to bill the Medi-Cal Dental Program
- However;

  0 to 6 months = 100%

  7 to 9 months = 75%

  10 to 12 months = 50%
- Authorization DOES NOT guarantee payment
- Payment is ALWAYS subject to patient eligibility

B-PRL-TRN-013.W

Resubmission Turnaround Document (RTD)

Medi-Cal Dental reviews each orthodontic claim, TAR and NOA to ensure that all the required information is present and correct. If an item has been omitted or is incorrect, the Medi-Cal Dental will issue an RTD. The RTD is a computer-generated form sent to request missing or additional information. This information must be received before the document can be processed.

Section "A" of the RTD lists the error(s) found on the original document and indicates the time limitation for response. Section "B" of the form is used to enter the requested information. After completion, sign and date the form, detach section "B" and return it to the Medi-Cal Dental program for processing. Retain section "A" of the RTD for the office records. Make certain to return the RTD promptly to Medi-Cal Dental. **The provider has 45 days in which to respond**. If the RTD is not returned within the time indicated, the Medi-Cal Dental program must deny the original document. Refer to the Provider Handbook, Section 6: Forms for complete instructions.

Specific to the orthodontic program, an RTD will be received 12 months into treatment inquiring if treatment is continuing. You must respond to the RTD within the time allowed, or any further treatment will be denied. In the case of a denial, a new TAR must be submitted requesting the remaining treatment plan. Procedures required on the new TAR are as follows:

1. Procedure D8670 (Periodic Ortho Treatment Visits x appropriate # of quarterly visits for case type requested)

2. Procedure D8680 x 1 (upper retainer)

3. Procedure D8680 x 1 (lower retainer)

The Resubmission Turnaround Document (RTD)

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

DHCS | Medi-Cal Dental

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 INFORMATION.

Adams, James, DDS
30 Center Street
Anytown, CA 95814

MEDI-CAL PROVIDER NO.: 1234567891

NOTICE — PAGE 01 OF PAGES 01

RTD ISSUE DATE	RTD DUE DATE
MM DD YY	MM DD YY

PATIENT NAME	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.
Last, First	XXXXXX999D			450.00	YY283170403

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		39		N		99	

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

A

RETAIN THIS PORTION

DETACH ALONG THIS PERFORATION

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY

MEDI-CAL DENTAL USE ONLY

DCN	CLAIM TYPE	PAGE	PAGES
YY283170403	T	01	01

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

TAR - ORTHO

BILLING PROVIDER NAME: Adams, James, DDS

MEDI-CAL PROVIDER NUMBER: 1234567891

PATIENT NAME: Last, First

PATIENT MEDI-CAL I.D. NUMBER: XXXXXX999D

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
N	39		99	A

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 the form.

X ______ 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.

B

RETURN THIS PORTION TO: MEDI-CAL DENTAL P.O. BOX 15609, SACR

The RTD For Continuing Ortho Treatment

PLEASE SIGN AND RETURN RTD TO CONTINUE AUTHORIZATION OF ORTHODONTIC TREATMENT

DOCUMENT CONTROL NUMBER * FOR DENTI-CAL USE ONLY

MEDI-CAL DENTAL USE ONLY

DCN	CLAIM TYPE	PAGE	PAGES
YY283170403	T	01	01

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

TAR - ORTHO

BILLING PROVIDER NAME: Adams, James, DDS

MEDI-CAL PROVIDER NUMBER: 1234567891

PATIENT NAME: Last, First

PATIENT MEDI-CAL I.D. NUMBER: XXXXXX999D

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
N	39		99	A

Leave Blank

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 the form.

X *Mary Smith* SIGNATURE — *MM DD YY* 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.

B

RETURN THIS PORTION TO: MEDI-CAL DENTAL P.O. BOX 15609, SACRAMENTO, CA 95852-0609

Electronic Funds Transfer (EFT)

- Medi-Cal Dental payments are deposited directly into a checking or savings account
- Complete a “Electronic Funds Transfer Enrollment Form”
- No more waiting for the mail service
- Notification of deposits will appear on the EOB

B-PRL-TRN-013.W

Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement which accompanies each Medi-Cal Dental payment received. The EOB lists all paid, modified and disallowed claims which have been processed during a payment cycle, as well as adjusted claims, and claims and TARs which have remained "in process" for more than 18 days. It also shows non-claims specific information, such as payable/receivable amounts and levy deductions. The EOB is an easy-to-read, comprehensive document which provides important payment information. Refer to the Provider Handbook, Section 6: Forms for a detailed explanation.

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

LINES PRECEDED BY “B” CONTAIN MEMBER INFORMATION

LINES PRECEDED BY “C” CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER No 1234567891

CHECK No 00596352

DATE: 08/15/YY PAGE NO. 1 of 3

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

B MEMBER NAME | MEDI-CAL I.D. NO. | MEMBER ID. | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STATUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

ADJUDICATED CLAIMS

B Last, First 99999999C 99999999C F mm/dd/yy
C YY135100013 D0140 05/07/YY P 50.00 35.00 35.00
CLAIM TOTAL 50.00 35.00 35.00

B Last, First 99999999E 99999999E M mm/dd/yy
C YY135100014 D0140 05/07/YY P 50.00 35.00 35.00
CLAIM TOTAL 50.00 35.00 35.00

*TOTAL ADJUDICATED CLAIMS 100.00 70.00 70.00

**PROVIDER CLAIMS TOTAL 100.00 70.00 70.00

ADJUSTMENT CLAIMS

B Last, First 99999999A 99999999A M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 02/02/YY A 318 -50.00 .00 .00
CLAIM TOTAL -50.00 .00 .00

B Last, First 99999999A 99999999A M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 02/02/YY P 50.00 35.00 35.00
CLAIM TOTAL 50.00 35.00 35.00

*TOTAL ADJUSTED CLAIMS .00 35.00 35.00

**PROVIDER CLAIMS TOTAL 50.00 35.00 35.00

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
70.00	35.00				105.00

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

LINES PRECEDED BY “B” CONTAIN MEMBER INFORMATION

LINES PRECEDED BY “C” CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER No 1234567899

CHECK No 00596352

DATE: 08/15/YY PAGE NO. 3 of 3

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

B MEMBER NAME | MEDI-CAL I.D. NO. | MEMBER ID. | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STATUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

DOCUMENTS IN-PROCESS

LAST NAME	FIRST NAME	MEDI-CAL ID	MEMBER - ID	DOB	DCN	AMT BILLED	*CODE	
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY168108150	567.00	C	IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY169103850	423.00	T	CS
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY175100684	112.00	C	IR

TOTAL DOCUMENTSIN-PROCESS 3 TOTAL BILLED 1102.00

* 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 XRAYS/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)

THE NEXT SCHEDULED ORTHO SEMINAR WILL BE HELD IN ANYTOWN ON mm/dd/yy FROM 8:30 AM TO 11:30 AM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON mm/dd/yy FROM 8:00 AM TO 12:00 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

B-PRL-TRN-014.X

Claim Inquiry Form (CIF)

Medi-Cal Dental has developed a form to simplify the provider inquiry and response process. The form is called the Claim Inquiry Form (CIF). This form provides an automated, quick response to any inquiries.

The first use for the CIF is to inquire about the status of a claim or TAR. The provider will receive a written response from Medi-Cal Dental called a Claim Inquiry Response (CIR). The second use for the CIF is to request reevaluation of a modified or denied claim or procedure that appears on the EOB. Always use a separate CIF for each inquiry. Complete all applicable areas on the CIF, including the provider number and DCN, and attach all related documentation. CIFs must be submitted within six months from the date of the EOB when requesting a reevaluation of a denied claim or procedure. Do not use a CIF to request a first-level appeal, or to request the reevaluation of a denied treatment plan on the NOA.

Inquiries using the CIF process are limited to only those reasons indicated on the form. Any other type of inquiry or request should be handled by telephone or written correspondence. Before submitting a CIF, use the toll-free line, (800) 423-0507 for any inquiries.

Claim Inquiry Form

Tracer Claim Inquiry Response

B-PRL-TRN-013.X

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- 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 MEDI-CAL DENTAL

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James DDS	1234567891
MAILING ADDRESS 30 Center Street	TELEPHONE NUMBER (XXX) XXX-XXXX
CITY, STATE Anytown, CA	ZIP CODE 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI)	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)	
Last, First	*YY147100009*	
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
999999999E		

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY	CLAIM RE-EVALUATION ONLY
Please advise status of: ☐ Claim for Payment. Attach a copy of form Date of Service ________________. ☐ Treatment Authorization Request (TAR). Attach a copy of form.	X Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional information)

Patient is now eligible for services rendered on MM DD YY. EVC# XXXXXX

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 *Mary Jones* ____________ MM DD YY ____________

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 MEDI-CAL DENTAL USE ONLY

OPER. I.D. ______________________________

ACTION CODE ______________________________

DC 003 (R 10/19)

Provider Appeal Process

The provider may request a First Level Appeal by submitting a formal written grievance to the Medi-Cal Dental program. Submission of a CIF is not required prior to the First Level Appeal. The appeal procedure is as follows:

1. The appeal must be submitted in writing to Medi-Cal Dental program within 90 days of the action precipitating the complaint or grievance. Do not use a CIF for this purpose.
2. The letter must specifically indicate a request for a First Level Appeal in order to ensure proper handling.
3. The appeal must clearly identify the claim or TAR in question and describe the disputed action.
4. Direct First Level Appeals to:

   Medi-Cal Dental Program

   Attn: Provider First Level Appeals

   P. O. Box 13898

   Sacramento, CA 95853-4898

Medi-Cal Dental staff (including professional review, if necessary) will review the appeal and respond in writing. Keep a copy of all documents related to the appeal.

JUDICIAL REMEDY

If dissatisfied with the decision received regarding the appeal, the option of seeking judicial remedy is available. 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.

First Level Appeals

1. Submit within 90 days
2. Use letterhead not a CIF
3. Letter must specifically request a 1st Level Appeal
4. Send all information/copies to uphold the request
5. Send Appeals directly to the Appeals address
6. Office will receive written notification from the Medi-Cal Dental program within 21 days
7. Last recourse with the Medi-Cal Dental Program

B-PRL-TRN-013.W

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER No 1234567899

CHECK No 00596352

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 08/15/YY PAGE NO. 1 of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B — MEMBER NAME | MEDI-CAL I.D. NO. | MEMBER ID. | SEX | BIRTH DATE

C — DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STATUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

ADJUSTMENT CLAIMS

B Last, First 999999999D 99999999D M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 0202YY A 318 -50.00 .00 .00
CLAIM TOTAL -50.00 .00 .00

B Last, First 999999999D 99999999D M mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED
C YY043100009 D0140 0202YY P 50.00 35.00 35.00
CLAIM TOTAL 50.00 35.00 35.00

*TOTAL ADJUSTED CLAIMS .00 35.00 35.00

**PROVIDER CLAIMS TOTAL 100.00 35.00 35.00

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
100.00	35.00				35.00

B-PRL-TRN-014.X

Requirements for Providers

- Senate Bill 639 – Effective July 1, 2020
- See Bulletin Volume 36, Number 4 (March 2020): Enhanced Protections for Medi-Cal Members
- Contains provisions regarding lines of credit
- Requires that dentist provide a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs

B-PRL-TRN-013.W

Senate Bill 639

- For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment

B-PRL-TRN-013.W

Free Services Offered

- Toll Free Lines for
  - Providers 1-800-423-0507
  - Members 1-800-322-6384
- Interactive Voice Response System (IVR)
- Onsite Training Visits
- Seminars
- Case Management and Care Coordination Services
- American Sign Language(ASL) and Language Services

For additional information and services see page 88-94 of the printed packet

B-PRL-TRN-013.W

American Sign Language

Medi-Cal Dental reminds providers that American Sign Language (ASL) translation and language assistance services are available to Medi-Cal members at no cost.

- Provider or member can request language assistance by calling the Telephone Service Center (TSC)
- Language assistance over the telephone or to schedule an ASL translator to be present at the time of the appointment.
- Providers can supply a language interpreter in the office, or providers can call the TSC to access language interpreters available in 250 languages and dialects.
- Free language tagline signs are available:

https://smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

B-PRL-TRN-013.W

Language Assistance Services

- Provider requesting translator for member should call:
  Telephone Service Center at (800) 423-0507
- Member requesting Translator should call:
  Telephone Service Center at 1-800-322-6384
- Members with hearing or speaking limitations can call:
  Teletext Typewriter (TTY) line at (800) 735-2922

(Monday through Friday, 8 a.m. to 5 p.m. at all other times, Medi-Cal members should call the California Relay Service TDD/TTY at 711 to receive the help they need.)

Refer to bulletin Volume 35, Number 12, in the bulletin section of the Medi-Cal Dental website.

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TELEPHONE INQUIRIES

Provider

For inquiries or general information, call the Medi-Cal Dental Program Customer Service Telephone Center toll-free at (800) 423-0507. When calling, please be prepared with the following information where applicable:

1. Billing provider name and provider number
2. Member's name and ID number
3. Type of treatment
4. Document Control Number of claim or TAR
6. Date of service and billed amount
7. Check voucher number

The TSC representatives are available to answer questions from 8:00 a.m. to 5:00 p.m. Monday through Friday (excluding holidays). The Medi-Cal Dental program encourages the use of the toll-free line for inquiries whenever possible. Most inquiries can be answered immediately by our telephone representatives. However, if the inquiry cannot be answered immediately, it will be routed to the telephone inquiry specialist and will be answered by mail within 10 days of the receipt of the original telephone call.

The Medi-Cal Dental program would like to give the best possible service and asks that the toll-free number be for provider assistance only. Please do not give the provider toll-free number to the Medi-Cal Dental members.

Medi-Cal Dental Members

The TSC toll-free line is available from 8:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays). The toll-free number is (800) 322-6384.

Members or their authorized representatives may use this toll-free number. Representatives must have the member's name and ID number in order to receive information from the California Medi-Cal Dental Program.

Information about the program is available from the member toll-free telephone operators. A few of the services are listed below:

1. Referrals to Medi-Cal Dental dentists
2. Complaints and grievances
3. Assistance with scheduling or rescheduling Clinical screenings
4. Information about Share of Cost and copayments
5. Information about denied, modified or deferred TARs

INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

The Medi-Cal Dental IVR is an automated inquiry system for use by providers. Using a touch-tone telephone, providers are able to communicate directly with an automated voice response system. Providers can access the IVR System by dialing the toll-free information line (800) 423-0507 from a touch-tone telephone. The IVR is available 24 hours a day, 7 days a week for information that can be accessed without a provider number. The menu options that do not require entering a provider number include:

- Billing criteria for procedures most frequently inquired about by providers
- Upcoming schedule of provider seminars for the caller's area
- A monthly news flash consisting of items of interest to providers
- Information about ordering Medi-Cal Dental forms
- Information about enrollment in the Medi-Cal Dental Program
- Transfer to a telephone representative for further inquiry

The hours for accessing information requiring a provider number are Monday through Sunday from 2:00 a.m. to 12:00 p.m. The optimum time to call is between 6:00 a.m. and 10:00 a.m. or between 3:30 p.m. and 5:00 p.m. when calls are at their lowest level. The menu options that do require entering a provider number include:

- Patient history relative to specific service-limited procedures
- Status of outstanding claims and/or TARs that the caller has submitted
- Provider financial information (next check amount and net earnings for the current or previous year)

HOSPITAL CASES

When dental services are provided in an acute care general hospital or a surgicenter, document the need for hospitalization (e.g., developmentally disabled, 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 the Medi-Cal Dental program. Prior authorization is required only for the following services in a hospital setting: laboratory processed crowns/bridges, prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from the Medi-Cal Dental program, even if they are provided in an outpatient hospital setting. In all cases, an operating room report or hospital discharge summary must be submitted with your claim for payment.

Services that require prior authorization may be performed on an emergency basis; however, the reason for the emergency services must be documented. Enclose a copy of the operating room report and indicate the amount of time spent in the operating room.

Hospital Inpatient Dental Services (Overnight or Longer)

If a provider is required to perform services within a hospital setting, the provision of the medical support services will depend on how the Medi-Cal member receives their medical benefits. Members may receive medical benefits through several different entities:

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

Refer to your Medi-Cal Dental Provider Handbook under “Section 4: Treating Members” to determine the entity providing a member medical services.

Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the Medi-Cal (FFS) Program

Authorization is required from Medi-Cal to admit the patient into the hospital.

This authorization must be submitted on the Medi-Cal Form 50-1, which should be sent directly to:

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 the Medi-Cal Dental program, this will only delay the authorization for hospital admission.

If your patient requires emergency hospitalization, a 'verbal' authorization is not available through the Medi-Cal field office. If the patient 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 patient as an emergency case and submit the 50-1 retroactively within ten working days to the Medi-Cal field office.

Your claim for payment of dental services is submitted to the Medi-Cal Dental program 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 Members Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans

The dentist must contact the patient's medical plan to arrange for hospital or surgical center admission and medical support services. All medical plans that provide services to Medi-Cal managed care members are contractually obligated to provide medical support services for dental treatment. If the Medi-Cal Field Office receives a Form 50-1 for a Medi-Cal patient who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

MAXILLOFACIAL-ORTHODONTIC SERVICES (MF-O)

All MF-O surgical and prosthetic services, TMJ dysfunction services, and services involving cleft palate/cleft lip require prior authorization. The exceptions to this are diagnostic services and those services performed on an emergency basis. Providers and their staff should be aware of the procedure codes specific to the MF-O program. These codes are listed in your Medi-Cal Dental Provider Handbook.

ORTHODONTIC SERVICES

Orthodontic benefits for eligible individuals under the age of 21 are available under the California Medi-Cal Dental Program when medically necessary. Services must be performed by a qualified orthodontist who is enrolled as a Medi-Cal Dental provider. This program covers handicapping malocclusion, cleft palate/lip, and cranio-facial anomalies cases. A Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet must be submitted to document the medical necessity. To document a handicapping malocclusion, it is necessary to have a minimum score of 26 on the HLD score sheet. There are also six automatic qualifying conditions: cleft palate deformity, cranio-facial anomaly, a deep impinging overbite causing destruction of the palatal soft tissue, an anterior cross-bite causing clinical attachment loss and recession of the gingival margin, severe traumatic deviation, or an overjet greater than 9mm or a mandibular protrusion greater than 3.5mm. See Provider Handbook, page 9-11 for more information.

CALIFORNIA CHILDREN'S SERVICES (CCS)

The CCS program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition. Patients must apply to CCS to be eligible for services provided under this program. The patient's caseworker can refer the patient to his or her local CCS county or regional office.

All CCS dental/orthodontic providers must be enrolled and active in the Medi-Cal Dental program prior to receiving payment. If a provider has a valid authorization issued by the CCS program, the authorization will be honored through the expiration date. Continue using the same processing guidelines that were in place when the services were authorized.

Program Guidelines:

All CCS members are subject to the scope of benefits, prior authorization and processing guidelines as defined in the Medi-Cal Dental Provider Handbook. The CCS Program only authorizes dental services if such oral conditions affect the member's /CCS-eligible condition. See Provider Handbook, page 9-1: Special Programs, for more information.

CCS/Medi-Cal: The CCS program will no longer issue authorizations for CCS/Medi-Cal members. Providers are to submit all claims and TARs directly to the Medi-Cal Dental program. If a member requires services beyond the scope of the Medi-Cal Dental program, they may qualify for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

CCS Only: CCS eligible members will continue to require service authorization requests (SARs) from CCS. Providers must request a SAR from the CCS county or regional office prior to submitting claims and TARs to the Medi-Cal Dental program.

THE PROFESSIONAL COMPONENT

The Medi-Cal Dental program has a professional unit consisting of dental consultants who are licensed dentists. The consultants review all claims and TARs which require professional judgment. These dental consultants assist the Medi-Cal Dental Program Provider/Member Services and Clinical Screening departments with reevaluations and special cases.

In addition, there are clinical screening dentists located throughout the state. They are responsible for pre-screening cases that may require clinical evaluation under the guidelines of the Medi-Cal Dental program.

After the clinical screening dentist has examined the patient, the screening report is reviewed by a Medi-Cal dental consultant. The claim or TAR is subsequently approved, modified, or denied. The Medi-Cal Dental clinical screening dentists also do post-operative screenings.

ONSITE TRAINING VISIT

Provider Representatives are available for On-site visits to assist providers with policy or billing issues that cannot be resolved by telephone or written correspondence. Medi-Cal Dental will determine the necessity to schedule an on-site training visit. To request a visit please contact the Telephone Service Center at (800) 423-0507.

SEMINARS

There are four types of Medi-Cal Dental Seminars- Basic/EDI, Advanced, Workshops and Orthodontic. All seminars are free of charge and offer continuing education credits based on the hours of training conducted. Visit the Medi-Cal Dental website at www.dental.dhcs.ca.gov or you may contact the telephone service center for the current seminar schedule and to make a reservation.

American Sign Language(ASL) and Language Services

American Sign Language (ASL) translation and language assistance services are available to Medi-Cal members at no cost. Either the Medi-Cal dental provider office or the member can call the Telephone Service Center (TSC) Monday through Friday, between 8 a.m. and 5 p.m. to request language assistance over the telephone or to schedule an ASL translator to be present at the time of the appointment. Providers can supply a language interpreter in the office, or providers can call the TSC to access language interpreters available in 250 languages and dialects..

Medi-Cal dental providers should call the Provider Telephone Service Center at (800) 423-0507 and Medi-Cal members should call the Medi-Cal Dental Telephone Service Center at 1-800-322-6384. Members with hearing or speaking limitations can call the Teletext Typewriter (TTY) line at (800) 735-2922, Monday through Friday, 8 a.m. to 5 p.m. At all other times, Medi-Cal members should call the California Relay Service TDD/TTY at 711 to receive the help they need.

CASE MANAGEMENT

Dental Case Management is designed to assist Medi-Cal members with special health care needs who are unable to schedule and coordinate complex treatment plans among multiple practitioners. This is a program designed for members with mental, physical and/or behavioral diagnosis or diagnoses who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers.

Some examples of qualifying special healthcare needs include physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or other limiting condition that requires medical management, health care intervention and/or use of specialized services or programs.
Referrals for Case Management services are initiated by the members' Medi-Cal dental provider, medical provider, case manager or case worker and are based on a current, comprehensive evaluation and treatment plan.

The Case Management referral form is located on the Medi-Cal Dental website: www.dental.dhcs.ca.gov. Members must be referred by a Medical or Dental professional by completing the secure online referral form. After completing the referral form, it must be emailed to DentalCaseManagement@delta.org. Please visit our Provider Forms Page/Dental Case Management section to download and submit a Case Management Referral form. If you have questions when submitting an online referral, please contact the Telephone Service Center at (800) 423-0507.

CARE COORDINATION SERVICES

Care Coordination services are offered by the Telephone Service Center (TSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our TSC representatives, who assist members with: Locating a General or Specialist, Dentist, Accessing Appointments, Translation Services, Transportation Assistance
Members can access the Care Coordination Services by contacting the Telephone Service Center at (800) 423-0507, and request Care Coordination assistance.

Additional Information

- Orthodontic procedures fee schedule
- Commonly used acronyms
- Orthodontic adjudication reason codes
- Phone numbers and other services
- CCS Information

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MEDI-CAL DENTAL FEE SCHEDULE FOR ORTHODONTIC SERVICES

Malocclusion, Cleft Palate and Cranio-facial Anomalies Cases		
		Maximum Allowance
D0140	Limited Oral Evaluation - All Case Types *(Initial Orthodontic Examination and completion of the Handicapping Labio Lingual Deviation (HLD) Index California Modification Score Sheet)*	35.00
D0470	Diagnostic Casts - All Case Types	75.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition - All Case Types *(Includes workup, photos, banding & materials)*	
	Malocclusion Case – Permanent Dentition	750.00
	Cleft Palate Case Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	925.00
	Craniofacial Case Primary Dentition	425.00
	Mixed Dentition	625.00
	Permanent Dentition	1000.00
D8210	Removable appliance therapy	245.00
D8220	Fixed appliance therapy	245.00
D8660	Pre-Orthodontic Treatment Visit *(for Cranio-facial Anomalies Cases Only)*	50.00
D8670	Periodic Orthodontic Treatment Visits - All Case Types	
	Malocclusion Case (8 quarterly visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	210.00
	Cleft Palate Case Primary Dentition (4 quarterly visits maximum – Up to 2 additional quarters may be authorized after initial phase of treatment)	125.00
	Mixed Dentition (5 quarterly visits maximum – Up to 3 additional quarters may be authorized after initial phase of treatment)	140.00
	Permanent Dentition (10 quarterly visits maximum – Up to 5 additional quarters may be authorized after initial phase of treatment)	300.00

	Cranio-facial Case Primary Dentition (4 quarterly visits maximum – Up to 2 additional quarters may be authorized after initial phase of treatment)	125.00
	Mixed Dentition (5 quarterly visits maximum – Up to 3 quarters may be authorized after initial phase of treatment)	140.00
	Permanent Dentition (8 visits maximum – Up to 4 additional quarters may be authorized after initial phase of treatment)	300.00
D8680	Orthodontic Retention - All Case Types *(Includes retainers & all adjustments)*	244.00
D8695	Removal of Fixed Orthodontic Appliance(s) – other than at conclusion of treatment	50.00
D8696	Repair of orthodontic appliance – maxillary	50.00
D8697	Repair of orthodontic appliance – mandibular	50.00
D8698	Re-cement or re-bond fixed retainer- maxillary	30.00
D8699	Re-cement or re-bond fixed retainer- mandibular	30.00
D8701	Repair of fixed retainers, includes reattachment- maxillary	50.00
D8702	Repair of fixed retainers, includes reattachment- mandibular	50.00
D8703	Replacement of lost or broken retainer- maxillary	200.00
D8704	Replacement of lost or broken retainer- mandibular	200.00
D8999	Band Removal *(per arch – no further treatment being provided)* Not a benefit to the original provider, requires documentation.	50.00

MOST COMMONLY USED ACRONYMS

TAR/CLAIM FORM	Treatment Authorization Request/Claim Form
NOA	Notice of Authorization
CIF	Claim Inquiry Form
RTD	Resubmission Turnaround Document
EOB	Explanation of Benefits
HLD INDEX	Handicapping Labio-Lingual Deviation Index California Modification Score Sheet
NPI #	National Provider Identifier Number
PIN	Personal Identification Number
CIN	Client Index Number
BIC	Benefits Identification Card
EVC #	Eligibility Verification Confirmation Number
AEVS	Automated Eligibility Verification System
POS	Point of Service Device
SOC	Share of Cost/Spend Down
CCS	California Children's Services

ADJUDICATION REASON CODES

See complete list of Reason Codes in Provider Handbook, Section 7

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 calendar quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
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.
	MAXILLOFACIAL SERVICES
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.
221	Procedure is only a benefit in conjunction with orthodontic treatment.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.

Phone Numbers and Websites

Provider Toll-Free Line (Medi-Cal Dental)	800-423-0507
Medi-Cal Dental Website	www.dental.dhcs.ca.gov
Member Toll-Free Line (Medi-Cal Dental)	800-322-6384
Members Website	www.smilecalifornia.org
A.E.V.S. (to verify eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S./Internet Help Desk	800-541-5555
Medi-Cal Website (to verify member eligibility)	www.medi-cal.ca.gov
EDI Technical Support	916-853-7373
Medi-Cal Dental Forms (fax number)	877-401-7534
Health Care Options	800-430-4263

Remove Other Coverage

Change Managed Care

CA Department of Public Health

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx

SPECIAL CASES

California Children's Services (CCS)

The California Children's Services (CCS) program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition.

All CCS dental providers must be enrolled and active, in the California Medi-Cal Dental Program (Medi-Cal Dental) to receive payment for treating CCS-eligible members.

CCS Eligibility

CCS-only and CCS/Medi-Cal members are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the Point of Service (POS) Network. For additional information about eligibility, refer to the Medi-Cal Dental Provider Handbook, Section 9: Special Programs.

A member's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treatment. When the member changes from the CCS/Medi-Cal program to the CCS-only program, providers must obtain a Service Authorization Request (SAR) from CCS, which is explained later in this section.

Processing Guidelines

CCS/Medi-Cal

The CCS program will no longer issue authorizations for CCS/Medi-Cal members. These members will be subject to the treatment prior authorization guidelines and scope of benefits as defined in the Medi-Cal Dental Provider Handbook. All claims, TARs, and associated documents are to be sent directly to Medi-Cal Dental.

CCS/Medi-Cal members requiring orthodontic services beyond the scope of the Medi-Cal Dental program, may qualify for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Prior authorization and documentation are required for these services and will be determined based on medical necessity.

The provider must contact CCS for CCS-only eligibility if a member is no longer eligible for Medi-Cal.

CCS-only

The following is an explanation of the CCS Service Authorization Request (SAR) process, the System-Generated SAR process, Service Code Groupings (SCG), and a list of related CDT 22 procedure codes.

Service Authorization Request (SAR) Process

CCS-only eligible members will require a Service Authorization Request (SAR) from the CCS program for orthodontic treatment. A SAR must be obtained from CCS before diagnostic and treatment services are provided. CCS does not pay for services rendered prior to the date of referral.

The CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (CDHS 4516) may be used to refer a member to the CCS program, and/or may be used by the dental office to request services for a member's CCS-eligible condition. (In the case of an emergency, the orthodontist may provide treatment, but must submit the SAR to the CCS office by the next business day). This form may be downloaded from The California Department of Health Services website at:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4516.pdf.
Instructions on how to complete this form are located on the back of the form. Orthodontic providers should use only the CDT- 22 procedure codes found in the Medi-Cal Dental Provider Handbook instead of medical procedure codes. The SAR may be faxed or mailed to the appropriate CCS county/regional office (see example of the CCS Dental and Orthodontic Client SAR form at the end of this section).

System-Generated SAR Process

If the requested services are medically necessary, the CCS program will determine the 'scope of benefits' and return a system-generated SAR to the dental office. The system-generated SAR is sent by mail only and will not be faxed (see example of the system-generated SAR form at the end of this section).

The SAR will list the Service Code Groupings number and/or individual CDT-22 procedure codes. The SAR will provide the CCS authorization begin date and end date. SAR's for orthodontic treatment are usually issued for up to one year. The SAR is not transferable between providers. Each provider who wishes to treat a CCS-only member must submit their own Dental and Orthodontic Client SAR form and receive a system-generated SAR from CCS.

After receiving the system-generated SAR, providers are to refer to the Medi-Cal Dental Provider Handbook to determine if a TAR is required. Orthodontists must follow the

Medi-Cal Dental policies and procedures to provide orthodontic services that are within the CCS authorized scope of benefits.

It is not necessary for the dental office to attach a copy of the CCS SAR to Medi-Cal Dental claims and TARs. CCS will electronically transmit the SAR to Medi-Cal Dental, which must be received before services can be paid or authorized.

When providers receive the system-generated SAR from CCS, they may conduct the orthodontic examination (which includes completion of the HLD Index Score Sheet) following the guidelines described in this packet.

If CCS-only members require services beyond the scope of the Medi-Cal Dental program, they may qualify for “Non Medi-Cal Benefits.” Providers will submit documentation directly to CCS, and will continue to use the CMS-1500 claim forms for these services.

Service Code Groupings (SCG)

An approved SAR will list the SCGs and/or individual procedure codes based on the provider’s requested treatment plan and the member’s medical condition. There are 18 SCGs which are grouped by treatment plans and procedure codes to assist the CCS program in determining services based on the member’s CCS-eligible medical condition. SCGs related to orthodontic services are listed in this section. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from CCS. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Medi-Cal Dental Provider Handbook, Section 5: Manual of Criteria.

A CCS SAR with an SCG or individual procedure code is only an authorization for the 'scope of benefits.' All Medi-Cal Dental policies, procedures, and requirements will apply to services authorized by a CCS SAR. Providers must refer to the Medi-Cal Dental Provider Handbook prior to treating a CCS-only member.

Following is the SCGs list for orthodontic services. For a complete listing of all SCGs, refer to the Medi-Cal Dental Provider Handbook, Section 9: Special Programs.

CCS-only Service Code Groupings for Orthodontic Services

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, 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

CCS-only Procedure Code Listing for Orthodontic Services
Medi-Cal Dental criteria applies to all procedure codes, as do all Medi-Cal Dental policies, procedures, and requirements. CCS-only member's have additional benefits and modifications based on frequency and age limitations. Providers may request SAR authorizations for the SCGs listed, or for additional procedure codes not listed in this table, refer to the Medi-Cal Dental Provider Handbook.

Procedure Code	Medi-Cal Dental Procedure Code Description	*Additional Criteria for CCS-only Benefits*
D0210	Intraoral, Complete Series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic Film	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	Cephalometric Film	Allowed for final records for orthodontic treatment
D0350	Oral/facial Images (including intra & extraoral images)	A benefit for final records for orthodontic treatment
D0470	Diagnostic Casts	One additional benefit for final records

Further information regarding the CCS program may be found in the Provider Handbook, Section 9: Special Programs.

Example of the CCS SAR used by providers to request authorization from CCS

(1 of 2 pages)

State of California—Health and Human Services Agency

Department of Health Care Services
California Children's Services (CCS)

CCS DENTAL AND ORTHODONTIC CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request | 2. Provider name | 3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person | 6. Contact telephone number ( ) | 7. Contact fax number ( )

8. Contact email address

Client Information

9. Client name—last | first | middle

10. Gender ☐ Male ☐ Female | 11. Date of birth (mm/dd/yy) | 12. CCS case number | 13. Home phone number ( )

14. Cell phone number ( ) | 15. Work phone number ( ) | 16. Email address

17. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

18. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

19. County of residence | 20. Language spoken | 21. Name of parent/legal guardian

22. Mother's first and last name | 23. Primary care physician (if known) | 24. Primary care physician telephone number ( )

Insurance Information

25. a. Enrolled in Medi-Cal? ☐ Yes ☐ No If yes, send TAR directly to Denti-Cal; no CCS SAR should be submitted | 25. b. If no, enter Client Index Number (CIN)

26. Enrolled in commercial dental insurance plan? ☐ Yes ☐ No | If yes, name of plan

Requested Services

27. Service Authorization Request for *(check all that apply)*
☐ a. CCS established client Diagnosis/ICD-10:____________________ ☐ b. CCS orthodontics ☐ c. Service Code Group (SCG)

28. Procedure Code/SCG	29. Tooth Number/ Letter/Arch	30. Description of Service (Including X-rays, prophylaxis, etc.)	31. Quantity	32. Fee
			33. Total fee:	

34. Is this a CCS supplemental services request ☐ Yes ☐ No | 35. Other documentation attached ☐ Yes ☐ No

36. Comments

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 mandatory information may result in your request being delayed or not being processed.

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 page two of this form.

37. Signature of dental provider or authorized designee | 38. Date

DHCS 4516 (09/15) Page 1 of 2

Example of the CCS SAR used by providers to request authorization from CCS

(2 of 2 pages)

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter either your Denti-Cal billing number (no group numbers) or NPI.
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.
8. Contact person's email address Enter the email address of the contact person.

Client Information

9. Client name: Enter the client's name—last, first, and middle.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS case number: Enter the client's CCS number. If not known, leave blank.
13. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
14. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
15. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
16. Email address: Enter the email address for the client or client's legal guardian.
17. Residence address: Enter the address of the client. Do not use a P.O. Box number.
18. Mailing address: Enter the mailing address if it is different than number 17.
19. County of residence: Enter residential county of the client.
20. Language spoken: Enter the client's language spoken.
21. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
22. Mother's first and last name: Enter the client's mother's name.
23. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
24. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

25. a. Is child enrolled in Medi-Cal? Mark the appropriate box. If answer is yes, do not send SAR to CCS, send TAR directly to Denti-Cal.
    b. If the answer is no, enter the Client Index Number (CIN).
26. Is child enrolled in a commercial dental insurance plan? Mark the appropriate box. If the answer is yes, enter the name of the commercial dental insurance plan.

Requested Services

27. a. CCS established client: Check if requesting approval for an established CCS client. Write diagnosis or ICD-10 code.
    b. CCS Orthodontics: Check if requesting approval for orthodontic services. (Check a. and b. if both apply.)
    c. Service Code Group (SCG): Check if covered by CCS SCG and enter SCG number in column 25. (Check a., b., & c. if all apply.) SCGs can be found in the Denti-Cal Provider Handbook at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Go to Section 9 Special Programs and scroll to SCGs.
28. Procedure Codes/Service Code Groups: Use the appropriate Denti-Cal American Dental Association's (ADA) Current Dental Terminology (CDT) codes for each service, and/or use CCS Service Code Group(s) (SCG). The CDT codes are found in Section 5 of the Denti-Cal Provider Handbook: http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf and the SCG are found in Section 9 of the Handbook, at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Do not duplicate individual procedure codes included in a SCG. Note: Denti-Cal does not use the latest CDT codes.
29. Tooth number or letter; arch; quadrant: Enter the universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use applicable arch codes U (upper), L (lower). Use quadrant codes UR (upper right), UL (upper left), LR (lower right), and LL (lower left).
30. Description of service: Furnish a brief description for each service. Standard abbreviations are acceptable.
31. Quantity: For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (procedure D0230); number of additional units for general anesthesia (procedure D9221).
32. Fee: Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.
33. Enter total fee to be charged.
34. Check yes or no box if this is a CCS Supplemental Services Request.
35. Check yes or no box if there is other documentation attached.
36. Comments. Enter any additional comments.

Signature

37. Signature of dental provider: Form must be signed by the dentist, orthodontist, or authorized representative.
38. Date: Enter the date the request is signed.

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Example of the system-generated SAR issued by CCS to the dental office

CONFIDENTIAL

SAR#

XXXXXXXX COUNTY CCS OR REGIONAL OFFICE
CALIFORNIA CHILDREN'S SERVICES (CCS)
ADDRESS 1
ADDRESS 2
CITY, ST ZIP
TELEPHONE:

AUTHORIZATION FOR SERVICES

Authorization is for services and effective dates indicated below, in accordance with CCS program policies and fee schedule. Authorization for additional services not listed below must be requested in advance. By providing these authorized services, I agree to accept payment from the CCS program as payment in full. If you have a Service Code Grouping (SCG) authorization, please check your Denti-Cal manual for services included in the SCG.

Authorized Provider: Facility Name
Line 1
Line 2
Line 3
City, St Zip

Provider No: 99999999999
Telephone: (999)999-9999

CCS CLIENT INFORMATION

Client Name: Name, Client
Parent/Guardian: Mr. and Mrs. Etc.
Address: Line 1
Line 2
City, State Zip

Client Index Number: 99999999A9
Medi-Cal Number #: 99999999999999
CCS Case Number: 9999999
Date of Birth: 9/99/9999
Telephone: (999) 999-9999

AUTHORIZATION INFORMATION

Effective Dates: 11/03/2018 through 11/30/2019

CCS AUTHORIZED SERVICES

<SERVICE CODE> or <SCG>	< *SERVICE CODE DESCRIPTION>*	*<QUANTITY>*

SPECIAL INSTRUCTIONS

<SPECIAL INSTRUCTIONS>

Please refer to the Denti-Cal manual for billing instructions. Thank you for your continued participation in the California Children's Services program.

Issued By: NAME, USER (XXXXX COUNTY OR REGIONAL OFFICE) Date Authorized: 12/01/2016

SAR#:

Dental SAR rules

1) Quantity should not display for service code groupings
2) The Authorized Provider name and address fields should fit into a standard window envelope
3) The Parent/Guardian name and address default from the primary addressee from patient registration