# Provider Bulletin

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### SIGN UP FOR OUR EMAIL LIST

Learn the latest Medi-Cal Dental news and information by signing up for our Medi-Cal Dental Fee-For-Service Provider email distribution list here.

### TRAINING SEMINARS

To reserve a spot online or view a complete list of training seminars, go to the Provider Training Seminar Schedule.

### PROVIDER ENROLLMENT ASSISTANCE LINE

Speak with an Enrollment Specialist. Go here for more information.

Available every Wednesday
8am - 4pm

# Reminder: Providers Must Renew Professional License

The Department of Health Care Services (Medi-Cal Dental) wants to remind you that your dental license must be active with the Dental Board of California to render services to Medi-Cal members. Medi-Cal Dental providers will automatically be inactivated from the Medi-Cal Dental program and will not be allowed to render services if their dental license is expired, revoked, inactivated, denied renewal, suspended, on probation, or subjected to other limitations by the Dental Board of California.

Per the Business and Professions Code, Section 1715, Dental Board of California licenses expire every two years on the last day of the licensee's birth month.

- If the licensee's birth year is in an even number year, their license will expire in an even-numbered year.
- If the licensee's birthday is an odd-numbered year, the license will expire in an odd-numbered year.

There is no grace period for a dentist in active practice, although a delinquency fee will not be assessed until the renewal is more than 30 days late. A licensee who practices after the expiration date without renewing is considered practicing without a license. Practicing without a license in the Medi-Cal Dental program will result in an overpayment which

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must be recovered.  Please take all necessary steps to prevent this from occurring for your practice by staying current with your licensure requirements.

The Dental Board of California sends reminder postcards to all license and permit holders' addresses on file approximately 90 days before the expiration date. If a provider does not receive a renewal postcard, they should visit the BreEZe webpage at www.breeze.ca.gov to renew. The Dental Board of California does not accept renewals by mail.

The Dental Hygiene Board of CA (DHBC) renews all California dental hygiene licenses every two years through the BreEZe webpage. For more information, please visit the DHBC Renewals and License Maintenance webpage.

For more information and assistance for other providers, please call (916) 263-2300, or send an e-mail to dentalboard@dca.ca.gov.

# Radiograph Exemption Clarification for Codes D4341 and D4342

The Department of Health Care Services (Medi-Cal Dental) wants to remind you that there is a radiograph exemption when submitting a Treatment Authorization Request (TAR) for periodontal scaling and root planing procedures.

Although prior authorization is required for Current Dental Terminology (CDT) codes D4341 (periodontal scaling and root planing – four or more teeth per quadrant) and D4342 (periodontal scaling and root planing – one to three teeth per quadrant), Medi-Cal Dental may consider a radiograph exemption for providers when deemed medically appropriate based on a patient's medical condition, physical ability, or cognitive function. Providers may submit a TAR with documentation, along with necessary photographs substantiating why radiographs of the patient are not possible.

In addition, prior authorization will continue to be waived for periodontal scaling and root planing procedures rendered to pregnant/postpartum members regardless of age, aid code, and scope of benefits when "PREGNANT" or "POSTPARTUM" is documented.

For more information, please refer to Section 5 (Manual of Criteria and Schedule of Maximum Allowances) of the Provider Handbook or contact the Telephone Service Center at (800) 423-0507.

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# Medi-Cal Dental Provider Billing Practices

The Department of Health Care Services (DHCS) would like to remind providers that they may not submit a claim to or collect reimbursement from a Medi-Cal member or an authorized representative except for the specified share of cost a member's eligibility status requires for any service. Title 22, California Code of Regulations, Section 51002 (a) and Welfare & Institutions Code (W&I Code) Section 14019.4 (a) expressly prohibits a provider from billing a Medi-Cal member for the cost of any service included in the Medi-Cal program's scope of benefits. Furthermore, a provider may not bill the member and Medi-Cal for the same dental procedure.

When Medi-Cal eligibility is verified, the provider may not treat the member as a private-pay patient to avoid billing Medi-Cal, obtaining prior authorization (when necessary), or complying with any other program requirement. In addition, upon receiving eligibility verification, the provider cannot bill the member for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or share of the cost. Providers cannot bill members for private insurance cost-sharing amounts such as deductibles, coinsurance, or copayments. (Page 2-18, Program Overview)

Before recommending or rendering non-covered benefits, providers should first fully explain to the member the treatment options available as covered benefits. Providers should not use administrative or quality of care denials (intentional or unintentional) as a reason to conclude that a procedure is a non-covered benefit. Providers should not require members to pay out of pocket for non-covered benefits as a precedent condition to providing covered benefits.

By law, a Medi-Cal provider must reimburse a member for a claim if the member provides proof of eligibility for the period during which the medically necessary covered service was rendered (and for which the member paid). (Page 2-19, Program Overview)

Medi-Cal providers shall check patient/member eligibility before rendering treatment. However, a private payment agreement with the patient/member is allowable under two scenarios.

1. The provider and member have agreed to have specific dental treatment performed outside of Medi-Cal Dental. The provider must have not verified the member's eligibility or submitted any TAR or claim to Medi-Cal Dental for the current phase of treatment.
2. The provider has submitted a specific procedure on a TAR or claim to Medi-Cal Dental

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that was subsequently denied on the basis that it was either not a benefit under Medi-Cal Dental's scope of benefits or it was denied because it did not meet the medically necessary criteria of the program or time/frequency limitations for the specific procedure.

If the denial was for technical or administrative reasons, the procedure CANNOT be billed to the member under any circumstances.

Providers can review details in the Provider Handbook Section 8 Fraud, Abuse and Quality Care subsection "Billing Medi-Cal Dental" (Page 8-12)

For more information, please contact the Provider Telephone Service Center at (800) 423-0507 or visit the Medi-Cal Dental website.

# Sign up for the Medi-Cal Dental Fee-For-Service Provider Email List to Stay Informed!

Do you want to be notified of critical Medi-Cal Dental updates as they occur? Would you like to receive the Provider Bulletins automatically in your email inbox? Sign up for the Medi-Cal Dental Fee-For-Service Provider Email Distribution List.

As a subscriber, you will receive critical news and information to help you serve your patients. From the Provider Application and Validation for Enrollment system to changes to Electronic Fund Transfer, you will receive critical information immediately as it happens.

Sign up today for the Medi-Cal Dental Fee-For-Service Provider Email Distribution List to stay informed!