California Medi-Cal Dental Program

Denti-Cal Bulletin

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DENTI-CAL BENEFICIARY REIMBURSEMENTS

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

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

WELFARE AND INSTITUTIONS CODE 14019.3

14019.3. (a) A beneficiary or any person on behalf of a beneficiary who has paid for medically necessary health care services, otherwise covered by the Medi-Cal program, received by the beneficiary shall be entitled to a return from a provider or directly from the department of any part of the payment that meets all of the following:

(1) Was rendered during the 90-day period prior to application for his or her Medi-Cal card, or after application for but prior to the issuance of his or her Medi-Cal card, for which the card authorizes payment under Section 14018 or 14019, or was charged to the beneficiary as excess co-payment during the period after issuance of his or her Medi-Cal card.

(2) Is not payable by a third party under contractual or other legal entitlement.

(3) Was not used to satisfy his or her paid or obligated liability for health care services or to establish eligibility.

(b) To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from a provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by a provider of the application of a beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

(c) Upon presentation of the Medi-Cal card or other proof of eligibility, a provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program.

(d) Notwithstanding subdivision (c), payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider, after making a full refund to the department of any Medi-Cal payments received for services, may recover all provider fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the care provided a beneficiary.

(e) A provider shall return any and all payments made by a beneficiary, or any person on behalf of a beneficiary, other than a third party obligated to pay charges by reason of a beneficiary's other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

a. To the extent permitted by federal law, the department shall waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to a pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of a beneficiary.

b. The department shall ensure payment to a beneficiary from a provider. A provider shall be notified in writing by the department when a beneficiary has submitted a claim to the department for reimbursement of services provided during the periods specified in paragraph (1) of subdivision (a). If a provider is not currently enrolled in the Medi-Cal program, the department shall assist in that enrollment. Enrollment in the Medi-Cal program may be made retroactive to the date the service was rendered.

c. If a provider fails or refuses to reimburse a beneficiary for services provided during the periods specified in paragraph (1) of subdivision (a), within 90 days of receipt by the department of a written request by a beneficiary or a representative of a beneficiary, the department may take enforcement action that may include, but shall not be limited to, any or all of the following:

    1) Withholding of future provider payments.

    2) Suspension of a provider from participation in the Medi-Cal program.

    3) Recoupment of funds from a provider.

i) If a provider fails or refuses to reimburse a beneficiary within 90 days after receipt by the department of a written request from a beneficiary or a

representative of a beneficiary, the department shall directly reimburse a beneficiary for medically necessary health care expenses incurred during the periods specified in paragraph (1) of subdivision (a). The department shall reimburse a beneficiary only to the extent that federal financial participation is available and only when the claim meets all of the following criteria:

1) The service was a covered benefit under the Medi-Cal program.
2) The provider was an enrolled Medi-Cal provider at the time the service was rendered.
3) The service was ordered by a health care provider, within the scope of his or her practice.
4) The beneficiary is eligible for reimbursement, as specified in subdivision (a).
5) The reimbursement shall be the amount paid by the beneficiary, not to exceed the rate established for that service under the Medi-Cal program.

j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action.