www.denti-cal.ca.gov

Denti-Cal
California Medi-Cal Dental
Bulletin

June 2010
Volume 26 , Number 12

This Issue:

Training Seminars:

Want to learn more about the Denti-Cal program? Come to one of our training seminars. Go to our website to **Reserve Your Spot**.

San Jose
Basic /D275 - June 10, 2010

Advanced /D276 - June 11, 2010

Riverside
Basic /D277 - June 24, 2010

Advanced/D278 –June 25, 2010

Exceptions to the Adult Dental Changes

Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) eliminated selected optional benefits under the Medi-Cal program, including most adult dental services for beneficiaries ages 21 and older. As a result, most dental services for adults ages 21 and older will no longer be payable under the Denti-Cal program with the following exceptions listed below.

Please note that for all procedures the criteria in the Manual of Criteria (MOC) will remain in effect and unless otherwise stated, all policies remain the same for payable dental services.

Beneficiaries under the Age of 21

The changes to adult dental services do not impact beneficiaries under the age of 21 who are EPSDT eligible.

A beneficiary under the age 21 whose course of treatment is scheduled to continue after he/she turns 21 years of age may be completed if certain conditions are met (see Bulletin Volume 25, Number 22). **Please note that orthodontic services must be completed by the beneficiary's 21st birthday.**

For more information, please see Bulletin Volume 25, Number 22.

Beneficiaries Ages 21 and Over

Beneficiaries ages 21 and over who are in full scope Aid Codes are eligible for the procedures

continued on pg. 2

REMINDER

Access attachments to the bulletin, such as forms, updated Handbook pages, and quarterly seminar schedules by clicking on the "Attachments" tab (Adobe Reader 7) or the paperclip icon (Adobe Reader 8 and 9) in the lower-left portion of the reading pane.

listed on "Table 1: Federally Required Adult Dental Services (FRADS)." The FRADS table is located in Section 4: Treating Beneficiaries of the Provider Handbook in addition to being attached to this bulletin.

Please note that many of the procedures listed in the FRADS list are for the relief of pain and infection. Beneficiaries should not go to an emergency room for routine care of pain and infection and should schedule an appointment with a provider to receive treatment.

For more information, please see Bulletin Volume 25, Number 22.

Pregnant Beneficiaries

Pregnant beneficiaries are still eligible for the pregnancy-related services found in "Table 2: Allowable Procedure Codes for Pregnant Women," which is located in Section 4: Treating Beneficiaries of the Provider Handbook in addition to being attached to this bulletin.

Pregnant beneficiaries are also eligible for the treatment of other conditions that might complicate the pregnancy (see link above to FRADS). These pregnancy-related services include 60 day postpartum care.

For more information, please see Bulletin Volume 26, Number 11.

Beneficiaries Residing in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF)

Beneficiaries receiving long-term care in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF), as defined in the Health and Safety Code (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k) are **exempt** from the change in adult dental services that became effective on July 1, 2009.

Additionally, beneficiaries residing in ICF-Developmentally Disabled (DD), ICF-Developmentally Disabled Habilitative (DDH) or ICF-Developmentally Disabled Nursing (DDN) facilities are exempt from the change in adult dental services that became effective on July 1, 2009.

Dental services do not have to be provided in the facility to be payable. Providers are reminded to follow the existing prior authorization and documentation requirements when treating patients that reside in a licensed SNF or ICF (including ICF-DD, ICF-DDH, and ICF-DDN).

For more information, please see Bulletin Volume 25, Number 23 and Bulletin Volume 25, Number 35.

Radiograph Requirements for Pregnant and Postpartum Beneficiaries

Effective June 1, 2010, for pregnant and postpartum beneficiaries the requirements for periodontal procedures are as follows:

- Gingivectomy (D4210 and D4211) – requires a current periodontal chart and photograph(s) of the involved areas.
- Osseous Surgery (D4260 and D4261) – requires a current periodontal chart **and periapical radiographs of the involved areas. Arch radiographs will be waived for pregnant beneficiaries.**
- Periodontal Scaling and Root Planing (D4341 and D4342) – requires a current periodontal chart **and periapical radiographs of the involved areas. Arch radiographs will be waived for pregnant beneficiaries.**
- **All other criteria stated in the Manual of Criteria (MOC) will apply.**

Note: "Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have the required pocket depths, a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted."

continued on pg. 3

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

All pregnant and postpartum beneficiaries (children and adults) in limited scope aid codes and adult pregnant/postpartum beneficiaries in full scope aid codes are allowed the following radiographic procedures:

D0220 Intraoral - periapical first film
D0230 Intraoral - periapical each additional film
D0270 Bitewing - single film
D0272 Bitewings - two films
D0274 Bitewings - four films

Claims must be submitted for all of the above procedures for limited scope beneficiaries only (a TAR is not required). For full scope beneficiaries under the age of 21 a TAR is required. For full scope beneficiaries (who normally qualify for FRADS procedures only) age 21 and older a TAR is not required, a claim must be submitted. Indicate "Pregnant" or "Postpartum" in the comments field (box 34) for all pregnant beneficiaries regardless of which of the above categories are applicable.

For questions, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.

Updated Emergency Dental Procedures for Omnibus Budget Reconciliation Act Beneficiaries

Omnibus Budget Reconciliation Act (OBRA) beneficiaries are newly legalized amnesty aliens and/or undocumented aliens who are otherwise eligible for Medi-Cal benefits but are not permanent U.S. residents. These beneficiaries have limited benefits and are only eligible for pregnancy-related (see Bulletin Vol. 26, No. 11) and/or emergency dental services (see Bulletin Vol. 26 No 10); they can be identified by their limited scope aid code.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

The emergency must be certified in accordance with Section 51056 of Title 22, CCR.

Due to the elimination of most optional adult dental benefits effective July 1, 2009, the emergency dental procedures for OBRA beneficiaries have also changed.

The following is an updated list of allowed emergency dental procedures for OBRA beneficiaries.

D0220, D0230, D0250, D0260, D0290, D0330, D0502, D0999, D2920, D2940, D2970, D3220, D3221, D6930, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7490, D7510, D7520, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7771, D7810, D7820, D7830, D7910, D7911, D7912, D7980, D7983, D7990, D9110, D9210, D9220, D9221, D9230, D9241, D9242, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9930.

For additional information or questions, please call the Denti-Cal Telephone Service Center at (800) 423-0507.

HIGHLIGHT

No Claim Activity for 12 Months

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

The department shall deactivate, immediately and without prior notice, the provider's number, including all business addresses used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you have not had any claim activity in a 12-month period, and wish to remain an active provider in the Denti-Cal Program, please click on the paperclip icon on the lower-left corner of the Adobe Acrobat Reader window to find the No Claim Activity form:

After completing the No Claim Activity form please mail it to:

Denti-Cal
California Medi-Cal Dental Program
PO Box 15609
Sacramento, CA 95852-0609

If your provider number is deactivated, you must reapply for enrollment in the Denti-Cal Program. To request an enrollment package contact Denti-Cal toll-free at (800) 423-0507.

Registering and Using National Provider Identifier (NPI) Numbers

Denti-Cal continues to encourage providers to obtain, register with Denti-Cal, and use National Provider Identifier (NPI) numbers. Providers who do not have an NPI number can request one from the National Plan and Provider Enumeration System (NPPES) Web site: https://nppes.cms.hhs.gov.

Registering NPI Numbers

Before providers can use their NPI numbers on Denti-Cal forms, both the billing NPI numbers and rendering NPI numbers ***must*** be registered with Denti-Cal.

Providers can register NPI numbers in one of two ways:

- Online via the Denti-Cal NPI Collection System. To expedite your NPI registration, register via the Denti-Cal NPI Collection System found on the Denti-Cal Web site.

  Go to http://www.denti-cal.ca.gov and click on the National Provider Identifier (NPI) tab, and then on the Register Your NPI link.

- Print the confirmation page from the Web site as a record of registration. After completing the registration process, please allow three (3) business days prior to submitting documents with NPI numbers.

- Using the NPI Registration Form DHS 6218. To obtain the paper NPI Registration Form DHS 6218 and instructions on how to register NPI numbers, visit the Denti-Cal Web site at http://www.denti-cal.ca.gov and click on the National Provider Identifier (NPI) tab, and then on the Register Your NPI link. Remember to retain a copy of the letter received from Denti-Cal as a record of registration. Providers should not use their NPIs when submitting documents for authorization or payment until they have received a confirmation letter from Denti-Cal, which can take up to 15 business days.

For questions with the Denti-Cal NPI Collection System or registration of NPI numbers, please call Denti-Cal toll-free at (800) 423-0507.

continued on pg. 5

Using NPI Numbers

Denti-Cal strongly encourages providers to use registered NPI numbers on the following forms:

- Treatment Authorization Request/Claim (DC-202, DC-209, DC-217)
- Claim Inquiry Form (DC-003)
- Forms Reorder Request (DC-204)
- Notice of Authorization (DC-301)

Unregistered NPI Numbers Can Lead to Denied Claims

Claims with unregistered NPI numbers will be denied with Adjudication Reason Code 319A, which reads as follows:

> **319A** The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.

To avoid denials on claims due to unregistered NPI numbers, providers should wait for confirmation of registration before using the NPI number.