

Denti-Cal California Medi-Cal Dental Bulletin

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Training Seminars:

Merced
Workshop /D271 - May 11, 2010

San Francisco
Ortho /D272 - May 20, 2010

Benefits for Pregnant and Post-partum Women

Replacement Bulletin

This bulletin replaces Denti-Cal Bulletin Volume 26, Number 6 (March 2010).

Denti-Cal would like to remind providers that pregnant beneficiaries in limited scope aid codes, including adults 21 years of age and older, are eligible for certain pregnancy-related services as well as treatment that is a covered benefit for conditions that might complicate the pregnancy.

Pregnancy-Related Benefits Extended to Additional Aid Codes

Effective June 1, 2010, pregnant **and post-partum** women in the following **limited scope** aid codes are eligible for **non-emergency** dental benefits listed below: C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, 0L, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 44, 48, 5F, 5J, 5R, 5T, 5W, 55, 58, 6U, 7C, 7G, 7K, 7N, 76, 8T and 8Y. **In addition, all pregnant and post-partum women age 21 and older in full scope aid codes are eligible for these same benefits.**

If you receive a denial ([Adjudication Reason Code 503A or 503B](#)) for a covered service for a pregnant/post-partum beneficiary, you should submit a Claim Inquiry Form (CIF) indicating "PREGNANT" or "POSTPARTUM" in the "REMARKS" field plus any additional documentation and radiographs pertinent to the procedure for reconsideration.

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REMINDER

Providers must report to Denti-Cal any modifications to information previously submitted within 35 days of the change. Forms and further information can be obtained on the Denti-cal Web site: www.denti-cal.ca.gov.



Pregnancy-Related Benefits Extend to Post-Partum Eligibility Period

Women eligible for pregnancy-related benefits remain eligible throughout the pregnancy **and the post-partum period** (which ends at the end of the month in which the 60th day post-partum occurs). Aid Code 76 is provided for the postpartum period. Therefore, the non-emergency dental benefits listed below are available to these women not only during pregnancy but also throughout the post-partum period. Note that the benefits in ***bold italics*** represent **new** pregnancy-related benefits.

- D0220 Intraoral - periapical first film***
- D0230 Intraoral - periapical each additional film***
- D0270 Bitewing - single film***
- D0272 Bitewings - two films***
- D0274 Bitewings - four films***
- D0120** Periodic oral evaluation (a benefit once in a six-month period for beneficiaries under age 21 only)
- D0150** Comprehensive oral evaluation - new or established patient (initial episode of treatment only)
- D1110** Prophylaxis – adult (once in a twelve-month period for beneficiaries age 21 and over)
- D1120** Prophylaxis – child (once in a six-month period for beneficiaries under age 21)
- D1201** Topical application of fluoride (including prophylaxis) – child (once in a six-month period for beneficiaries under age 21)
- D1203** Topical application of fluoride (prophylaxis not included) – child (once in a six-month period for beneficiaries under age 21)
- D1204** Topical application of fluoride (prophylaxis not included) – adult (once in a twelve-month period for beneficiaries age 21 and over)
- D1205** Topical application of fluoride (including prophylaxis) – adult (once in a twelve-month period for beneficiaries age 21 and over)
- D4210** Gingivectomy or gingivoplasty- four or more contiguous teeth or bounded teeth spaces per quadrant
- D4211** Gingivectomy or gingivoplasty- one to three teeth, per quadrant
- D4260** Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant
- D4261** Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant
- D4341** Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
- D4342** Periodontal scaling and root planing - one to three teeth, per quadrant
- D4920** Unscheduled dressing change (by someone other than treating dentist)
- D9951** Occlusal adjustment – limited

Claims must be submitted for all of the above procedures. Do not submit TARs for pregnancy related services.

A current periodontal chart is required for all surgical periodontal procedures along with photographs for procedures D4210 and D4211. In addition, all criteria stated in the Manual of Criteria (MOC) will apply with the following exceptions:

D4260 and D4261 Osseous Surgery - arch radiographs are **not** required but periapical radiographs of the involved areas **are** required.

D4341 and D4342 Periodontal Scaling and Root Planning - arch radiographs are **not** required but periapical radiographs of the involved areas **are** required.

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The following policy will be applied for all claims submitted for the procedures indicated above: If the beneficiary is in a limited scope aid code of C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, 0L, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 44, 48, 5F, 5J, 5R, 5T, 5W, 55, 58, 6U, 7C, 7G, 7K, 7N, 76, 8T or 8Y, or in full scope Aid Code 86 or 87, and is **currently pregnant**, indicate “**PREGNANT**” in the “Comments” area (Box 34) of the claim form. If the patient has already delivered but is **in the 60+-day post-partum period** of eligibility, or in Aid Code 76, indicate “**POST-PARTUM**” in the “Comments” area.

Changes to the Scope of Emergency Dental Services

Pregnant and post-partum beneficiaries in limited scope aid codes are also eligible to receive the emergency dental services listed below. **Note that while there is some overlap, these procedures are not synonymous with Federally Required Adult Dental Services (FRADS).** For claims for emergency services, a clinical emergency certification statement and, when applicable, radiographs and/or other documentation to justify the procedure must be submitted. Providers must follow the emergency certification instructions below to document the emergency. **Simply stating “Pregnant” or “Post-Partum” for emergency procedures without further documentation of the emergency is insufficient and the claim will be denied.**

*The following procedures are allowable as emergency dental procedures for pregnant or post-partum women in the following **limited scope** aid codes:*

Limited Scope Aid Codes Eligible for Emergency Dental Procedures	Emergency Dental Procedures
C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, 0L, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5F, 5J, 5R, 5T, 5W, 55, 58, 6U, 7C, 7G, 7K, 8T, 8Y	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

Note: Women in the above aid codes may be eligible for **both** the pregnancy-related benefits described above, which are only available to pregnant/post-partum women, and the **non-pregnancy-related emergency benefits**, which are available to women (pregnant or not), men, and children whose Medi-Cal coverage is limited to “emergency services only.”

When the procedures listed above are provided for beneficiaries in one of the above aid codes (regardless of whether they are pregnant or post-partum), an emergency certification statement is always required. This statement must be either entered in the “Comments” area (Box 34) on the claim form or attached to the claim. It must:

- Describe the nature of the emergency, including clinical information pertinent to the beneficiary’s condition; and
- Explain why the emergency services provided were considered immediately necessary.

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HIGHLIGHT

For Faster Denti-Cal Payments, Enroll in Direct Deposit Today!



Denti-Cal encourages providers to enroll in the direct deposit program. With direct deposit, Denti-Cal automatically deposits its payments into a provider's designated savings or checking account, which means:

- No more lost or misdirected checks
- No more waiting for checks to arrive in the mail
- No more trips to the bank
- Payments are available faster

To participate in the program, providers must complete and sign a Direct Deposit Enrollment Form. Providers can obtain a form by calling the Telephone Service Center at (800) 423-0507, or by writing to Denti-Cal at this address:

Denti-Cal
Attn: Provider Enrollment Department
PO Box 15609
Sacramento, CA 95852-0609

The back of the form contains instructions for completing the Direct Deposit Enrollment Form. The Direct Deposit Enrollment Form must include the following:

- The provider's original signature (in blue ink)
- A preprinted, voided check attached to the form

Providers must mail the completed form to Denti-Cal at the address shown above.

Upon receipt of the Direct Deposit Enrollment Form, Denti-Cal sends a "test" deposit to the bank. This will result in a "zero" deposit for that payment date. The test cycle usually takes three to four weeks to complete. During the test cycle period, providers will continue to receive Denti-Cal payment checks through the mail.

The amount of each deposit will appear on the corresponding Explanation of Benefits once direct deposit begins.

More information about direct deposit can be found in "Section 3: Enrollment Requirements" of the provider Handbook.

The statement must be signed by the dentist providing the services (in the "Comments" area or on the attached statement) and must provide enough information to show the existence of an emergency dental condition and need for immediate treatment. **Merely stating that an emergency existed or that the patient was in pain is insufficient.** When applicable, necessary documentation and/or radiographs to justify the procedure must be submitted with the claim.

Federally Required Adult Dental Services (FRADS)

In addition to the pregnancy-related and post-partum dental benefits noted above, **all** pregnant and post-partum adult women in **full scope** Aid Codes are also eligible for **FRADS**. You can determine whether women are in full scope aid codes when you check eligibility. You can also see a list of aid codes eligible for full scope benefits [here](#). Please refer to [Denti-Cal Bulletin Volume 25, Number 22, May 2009](#), for a list of the covered FRADS procedures.

Digitized Images and Electronic Data Interchange (EDI) Documents

In conjunction with electronically submitted documents, Denti-Cal accepts digitized images submitted through electronic attachment vendors: National Electronic Attachment, Inc. (NEA), National Information Services (NIS) and Tesia-PCI, LLC.

Providers must be enrolled to submit documents electronically prior to submitting digitized images.

For more information on enrollment, providers can contact the Telephone Service Center toll free at (800) 423-0507 or EDI Support at (916) 853-7373 (email: denti-caledi@delta.org).

Digitized radiographs, photographs, periodontal evaluation charts, scanned State-approved Justification of Need for Prosthesis forms (DC 054), and other narrative reports may be submitted in conjunction with EDI claims and TARs through NEA, NIS or Tesia-PCI, LLC Web sites.

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Images that CAN Be Transmitted:	Images that CANNOT Be Transmitted:
<ul style="list-style-type: none"> ◆ Documentation related to claims and TARs to be submitted electronically: <ul style="list-style-type: none"> • Radiographs • Periodontal Evaluation Charts • Justification of Need for Prosthesis Forms (DC-054) • Photos • Narrative documentation (surgical reports, etc.) 	<ul style="list-style-type: none"> ◆ Any documentation related to claims and TARs submitted on paper ◆ CIFs, RTDs, or NOAs related to paper or EDI documents

ELECTRONIC VENDOR AND DOCUMENT SPECIFICATIONS

NEA USERS: Digitized radiographs and attachments must be transmitted to NEA before submitting an EDI document. NEA's reference number must be entered in the first line of the Comments section of the EDI document in the following format: "NEA#" followed by the reference number, with no spaces - Example: NEA#9999999. Any additional comments should be entered in the Comments field following the digitized image reference number. It is important to use this format and sequence.

Some dental practice management and electronic claims clearinghouse software have an interface with NEA that automatically enters the reference number into the notes of the claim. For additional information, providers can visit www.nea-fast.com or call (800) 782-5150.

NIS USERS: The EDI document should be created. Before transmitting a document electronically, the digitized radiographs and attachments should be attached. The Document Center should be used to scan images of Denti-Cal's Justification of Need for Prosthesis Form (DC-054), perio charts, photos, etc. The date images were created should be entered in the notes for each attachment. For additional information, providers can visit www.nationalinfo.com or call (800) 734-5561.

Tesia-PCI, LLC: Create the claim or TAR. Before transmitting a document electronically, the digitized images should be created and attached. Each attachment must include the date the images were created. For additional information, providers can visit www.tesia.com or call (800) 724-7240.

Helpful Hints for Using the Telephone Automated Eligibility Verification System (AEVS)

The Telephone Automated Eligibility Verification System (AEVS) is an interactive voice response system allowing providers to access beneficiary eligibility and update Share of Cost (SOC). The phone number for AEVS is 1-800-456-2387.

Please note that AEVS is not maintained by Denti-Cal: providers experiencing technical difficulties need to contact the AEVS Point of Service (POS) Help Desk at 1-800-427-1295.

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Helpful Hints

The following are some helpful hints when using telephone AEVS:

- ◆ **Prior to Calling AEVS:** Have all necessary information ready (i.e. pin number, beneficiary ID number, and beneficiary date of birth), as well as pen and paper to write information down.
- ◆ **Hours of Operation:** AEVS is available from 2 A.M until midnight, seven days a week.
- ◆ **Time Limits:** When prompted for a response, telephone AEVS will wait for five seconds. If after the third reminder no response is detected, the connection will be terminated.
- ◆ **Error Limits:** AEVS allows for three opportunities to enter correct information. After the third error, AEVS terminates the connection.
- ◆ **Eligibility Information:** Each inquiry received by AEVS having an eligible response results in AEVS providing an Eligibility Verification Confirmation (EVC) number. The EVC number should be noted in your patient's records for future reference.
- ◆ **Inquiry Limits:** Providers are limited to a maximum of 10 inquiries for each telephone call. An inquiry that has been resubmitted because of a previous error is considered an additional inquiry.

More information about AEVS can be found in the AEVS user guides located on the Medi-Cal Web site at http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp.

For questions on the above, or any other information, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.