Section 9 - Special Programs

Section 9 - Special Programs

California Children's Services (CCS)

The CCS program provides health care to children and adolescents under 21 years of age who have a CCS-eligible medical condition.

The CCS program provides diagnostic and treatment services, medical case management, some dental services, and physical and occupational therapy services. The CCS program only authorizes dental services if the member's CCS-eligible medical condition or oral condition can be affected. Examples of medical conditions of children who are CCS-eligible for dental services include cerebral palsy, cystic fibrosis, hemophilia, certain heart diseases, certain cancers, traumatic injuries to the face and mouth, cleft lip/palate, and other craniofacial anomalies. CCS offers orthodontics to children with medically handicapping malocclusions, cleft lip/palate, and craniofacial anomalies.

Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation. The referral to the CCS county program or CCS State Regional Office may be made by fax, phone call, correspondence, or the CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (CDHS 4516). CCS will not cover any services provided prior to the date the referral was received by the CCS program.

CCS serves approximately 175,000 children who have the following types of program eligibility:

- CCS/Medi-Cal: These members are eligible for full scope dental benefits with no share of cost under Medi-Cal. They may have case coordination services provided by CCS. The provider shall submit TARs and Claims directly to Medi-Cal Dental, comply with all program requirements and obtain prior authorization (when necessary) in order for services to be paid.
- CCS-only: These members are children whose family's annual income is below $40,000, or whose estimated out-of-pocket expenses to treat the CCS eligible condition exceed 20% of a family's income. They receive health care funded by the State and the counties and are limited to the treatment of their CCS-eligible conditions.

Genetically Handicapped Person's Program (GHPP)

The GHPP is a State-funded health care program for adults and some children with certain genetic diseases. GHPP coordinates care and payment for persons usually over the age of 21 years with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.

The GHPP serves adults and some children who have the following types of program eligibility:

- GHPP/Medi-Cal: These members may be eligible for dental benefits under the GHPP.

- GHPP-only: These members receive comprehensive State-funded dental and health care benefits under GHPP.

CCS-only and Authorizations and Claims Processing

To begin the CCS process for dental services, the provider must submit a CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (DHCS 4516) to the CCS county program. The provider may fax or mail this form to the CCS county program. The CCS county program will review the requested dental services and determine if the patient qualifies for the services based on their CCS-eligible medical condition.

Providers are required to obtain an approved SAR from the CCS county program of the member's county of residence, or CCS State Regional Office, prior to performing dental services. An approved SAR only authorizes the dental scope of benefits.

The CCS county program will issue a CCS SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of Medi-Cal Dental.

Providers are to adhere to all Medi-Cal Dental policies and TAR/Claim submission requirements. Refer to the Orthodontic Services Program in this section as well as "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Providers do not have to attach the SAR to the Medi-Cal Dental TAR/Claim. CCS electronically notifies Medi-Cal Dental Program of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact CCS to obtain a new SAR prior to submitting a re-evaluation.

CCS/Medi-Cal Authorizations and Claims Processing

Members with CCS/Medi-Cal eligibility do not require a CCS SAR. These members have full scope Medi-Cal eligibility and are only case managed by CCS. No CCS SAR request should be submitted.

CCS/Medi-Cal claims and TARs are to be sent directly to the Medi-Cal Dental Program. Providers may submit a TAR requesting EPSDT services for a Medi-Cal member requiring dental benefits beyond the scope of the Medi-Cal Dental Program. Refer to EPSDT services in this section.

GHPP/Medi-Cal and GHPP-only Authorizations and Claims Processing

To begin the GHPP process for dental services, the provider must submit a GHPP Dental Client Service Authorization Request (SAR) (MC 2361) to the GHPP State office. The provider may fax or mail this form to the GHPP State office. The GHPP will review the requested dental services and determine if requested services are medically necessary.

The GHPP will issue a GHPP SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of Medi-Cal Dental.

Providers are to adhere to all Medi-Cal Dental policies and TAR/Claim submission requirements. Refer to "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Providers do not have to attach the SAR to the Medi-Cal Dental TAR/Claim. GHPP electronically notifies Medi-Cal Dental of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact GHPP to obtain a new SAR prior to submitting a re-evaluation.

Orthodontic Services for CCS-only Members

The CCS program has adopted the Medi-Cal dental orthodontic criteria for children with handicapping malocclusion, cleft lip/palate, and craniofacial anomalies. Orthodontic diagnostic and treatment criteria are contained within “Section 5: Manual of Criteria and Schedule of Maximum Allowances” for Medi-Cal Authorization (Dental Services) in this Handbook.

Providing Orthodontic Services to Medi-Cal Dental Members

In order to provide orthodontic services to Medi-Cal Dental or CCS members, a provider must be “actively” enrolled in Medi-Cal Dental and be enrolled as a Certified Orthodontist. Refer to “Section 3: Enrollment Requirements” of this Handbook for additional information regarding enrollment. If the provider is uncertain of his/her current Medi-Cal Dental status, he/she may phone the Telephone Service Center at (800) 423-0507 and request an Orthodontic Provider Enrollment Form.

As defined in Title 22, California Code of Regulations, Section 51223(c), a qualified orthodontist is a dentist who confines his/her practice to the specialty of orthodontics and has:

- Successfully completed a course of advanced study on orthodontics of two years or more in a program recognized by the Council on Dental Education of the American Dental Association, or
- Completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontics.

Eligibility

CCS:

CCS/Medi-Cal dental providers are to request an approved CCS SAR from the CCS county program or CCS State Regional Offices for CCS-only and dental services and then submit TAR/Claim forms to Medi-Cal Dental.

CCS/Medi-Cal:

Medi-Cal dental providers are to submit TARs/Claims directly to Medi-Cal Dental and do not require a CCS SAR.

GHPP:

GHPP providers are to request an approved GHPP SAR from the State GHPP office for GHPP/Medi-Cal and GHPP-only dental services and then submit TAR/Claim forms to Medi-Cal Dental.

Note: CCS and GHPP SARs are not transferable between dental providers.

Changes in the Member's Program Eligibility

CCS-only, GHPP-only, CCS/Medi-Cal, and GHPP/Medi-Cal members are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the AEVS, POS Device, and/or the Medi-Cal website. A member's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treating the member.

When the member changes from the CCS/Medi-Cal program to the CCS-only program, providers must obtain a SAR from the CCS county program. A SAR is not required for members who change from the CCS-only program to CCS/Medi-Cal. Providers are to refer to this Handbook prior to treating CCS-only, CCS/Healthy Families, CCS/Medi-Cal, and GHPP/Medi-Cal members.

Providers will need to submit separate claim forms when a patient's program eligibility changes. This will expedite Medi-Cal reimbursement in the event that a CCS county has insufficient funds to process claims with CCS-only or benefits. If the CCS county program/State GHPP program does not have sufficient funds, claims will be withheld until sufficient funds are available.

Note: CCS-only members residing in Los Angeles County will not be issued a BIC.

Emergency Treatment

CCS-only Members: If there is an emergency condition, then the provider may treat the member for the emergency. The provider is required to submit the appropriate form (CDHS 4488 or CDHS 4509) to the CCS county program or CCS State Regional Office by the next business day, requesting a SAR.

CCS/Medi-Cal Members: Providers should refer to "Section 4: Treating Members" of this Handbook for procedures for approval and payment for emergency dental services and for obtaining appropriate authorization for services dictated by emergency situations, which preclude timely advance requests for Medi-Cal Dental TAR/Claim forms.

GHPP/Medi-Cal and GHPP-only Members: If there is an emergency condition, then the provider may treat the member for the emergency. The provider is required to submit the appropriate form (MC 2361) to the State GHPP office by the next business day, requesting a SAR.

Other Coverage

A CCS or GHPP member may have other dental coverage (i.e., managed care or indemnity dental insurance coverage). Members must apply their other coverage benefits prior to utilizing CCS or GHPP benefits. Other coverage will be considered as the primary carrier, and CCS or GHPP will be considered as the secondary carrier and payer of last resort.

CCS-only, GHPP/Medi-Cal and GHPP only Service Code Groupings (SCG)

An approved SAR will list the SCGs and/or the individual procedure code(s) based on the provider's requested treatment plan and the member's CCS or GHPP-eligible medical condition. These 18 SCGs are grouped by treatment plans and procedure codes to assist the CCS county program or CCS State Regional Office in authorizing services based on the member's CCS-or GHPP-eligible medical condition. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from the CCS county program or GHPP State office. 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 scope of benefits.

SCG 01 – Preventive Dental Services
D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1320, D1351, D1352, D1999, D9920, D9995, D9996

SCG 02 – Orthodontic Services for Medically Handicapping Malocclusion
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 03 – Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 04 – Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 05 – Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 06 – Primary Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 07 – Mixed Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 08 – Permanent Dentition for Facial Growth Management Orthodontic Services
D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 09 – Oral Surgery Services
D1510, D1516, D1517, D1526, D1527, D1556, D1557, D1558, D1575, D5211, D5212, D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7961, D7962, D9222, D9223, D9230, D9239, D9243, D9248, D9610

SCG 10 – Periodontic Services
D4210, D4211, D4260, D4261, D4341, D4342, D4355, D4910, D9110, D9222, D9223, D9230, D9239, D9243, D9248

SCG 11 – Endodontic Services
D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3921, D9222, D9223, D9230, D9239, D9243, D9248

SCG 12 – Restorative Services
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2941, D2951, D3220, D3222, D3230, D3240, D9222, D9223, D9230, D9239, D9243, D9248

SCG 13 – Laboratory Crown Services
D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791, D9222, D9223, D9230, D9239, D9243, D9248

SCG 14 – Fixed Prosthetic Services
D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D9222, D9223, D9230, D9239, D9243, D9248

SCG 15 – Prosthetic Services for Complete Dentures
D5110, D5120, D5130, D5140, D5863, D5865

SCG 16 – Prosthetic Services for Cast Partial Dentures
D5213, D5214

SCG 17 – Prosthetic Services for Resin Partial Denture
D5211, D5212

SCG 18 – Dental Services under General Anesthesia
D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1352, D1510, D1516, D1517, D1526, D1527, D1556, D1557, D1558, D1575, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3222, D3230, D3240, D3310, D3320, D3330, D3346, D3347, D3348, D3410, D3421, D3425, D3426, D4210, D4211, D4260, D4261, D4341, D4342, D4355, D4910, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D9110, D9222, D9223, D9239, D9243, D9420

CCS-only Benefits

The CCS and GHPP program have the same scope of benefits as Medi-Cal Dental with a few exceptions:
CCS-only, GHPP/Medi-Cal and GHPP only (if applicable) have additional benefits and modifications based on frequency and age limitations. The table below lists the additional benefits.

Note: The reimbursement rates are the same as those on the Medi-Cal Dental Schedule of Maximum Allowances (SMA).

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D0210	Intraoral - complete series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic radiographic image	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis	Allowed for final records for orthodontic treatment
D0350	2D Oral/Facial photographic images obtained intra-orally or extra orally	A benefit for final records for orthodontic treatment
D0470	Diagnostic casts	One additional benefit for final records
D1120	Prophylaxis - child	A benefit 4 times per year for prophy or prophy/fluoride
D1206	Topical application of fluoride varnish	A benefit 4 times per year

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D1208	Topical application of fluoride - excluding varnish	A benefit 4 times per year
D1351	Sealant – per tooth	A benefit: First deciduous molars (B, I, L, and S)
D1351	Sealant - per tooth	A benefit: Second deciduous molars (A, J, K, and T)
D1351	Sealant – per tooth	A benefit: First bicuspids (5, 12, 21 and 28)
D1351	Sealant - per tooth	A benefit: Second Bicuspids (4, 13, 20, and 29)
D1352	Preventive resin restoration	A benefit: First deciduous molars (B, I, L, and S)
D1352	Preventive resin restoration	A benefit: Second deciduous molars (A, J, K, and T)
D1352	Preventive resin restoration	A benefit: First bicuspids (5, 12, 21 and 28)
D1352	Preventive resin restoration	A benefit: Second Bicuspids (4, 13, 20, and 29)
D1510	Space maintainer-fixed – unilateral – per quadrant	A benefit to hold space for missing permanent posterior tooth.
D1516	Space maintainer - fixed – bilateral, maxillary *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1517	Space maintainer - fixed – bilateral, mandibular *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1526	Space maintainer – removable – bilateral, maxillary *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1527	Space maintainer – removable – bilateral, mandibular *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1575	Distal shoe space maintainer – fixed – unilateral-per quadrant	A benefit to hold space for missing permanent posterior tooth.
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	No age restrictions
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more	No age restrictions

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
	contiguous teeth or tooth bounded spaces per quadrant	
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	No age restrictions
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	No age restrictions
D4910	Periodontal maintenance	No age restrictions
D5110	Complete denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5120	Complete denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5130	Immediate denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5140	Immediate denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3rd molars.
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rest and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3rd molars.
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D5863	Overdenture – complete maxillary *Effective March 14, 2020	A benefit once in a five year period.
D5865	Overdenture – complete mandibular *Effective March 14, 2020	A benefit once in a five year period.

Contact Listings for Medi-Cal Dental, Medi-Cal Eligibility, GHPP, and CCS

Medi-Cal Dental Program Providers are to contact Medi-Cal Dental for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and GHPP-only questions related to payments of claims and/or authorizations of TARs.	
Provider Toll-Free Line	(800) 423-0507
Member Toll-Free Line	(800) 322-6384
Electronic Data Interchange (EDI) Support	(916) 853-7373
Ordering Medi-Cal Dental Forms	Fax (877) 401-7534
Medi-Cal Program Providers are to contact the Medi-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only and GHPP-only eligibility, POS, or Internet questions.	
Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk, POS, and/or Internet Help Desk	(800) 541-5555
Internet Eligibility Website	Click here
GHPP State Office Providers are to contact the State GHPP office for questions related to authorizations for services issued prior to January 31, 2011.	
Toll Free	(800) 639-0597
Toll	(916) 327-0470
Fax	(916) 327-1112
Genetically Handicapped Persons Program: MS 8200 PO Box 997413 Sacramento, CA 95899	

CCS-only County Programs and CCS State Regional Offices

- CCS website and contact information
- Providers are to utilize the following guidelines when selecting the correct CCS county program or CCS State Regional Office:

- For questions on eligibility, SAR authorizations, and submitting claims in Independent counties, please contact the CCS Independent county office listed on the CCS website here.
- For questions on eligibility in Dependent counties, please contact the CCS Dependent county office or the appropriate CCS State Regional Office listed above.
- For questions on prior authorization or submitting claims in Independent counties, contact the appropriate CCS State Regional Office listed above.

GHPP/Medi-Cal and GHPP-only State Office

- GHPP website and contact information

Orthodontic Services Program

Medi-Cal dental benefits include medically necessary orthodontic services. Services available under this program are limited to only those members that meet the general policies and requirements. These benefits are available to eligible individuals before their 21st birthday. Policies governing the provision of these program benefits are listed in "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Qualified orthodontists may provide orthodontic services to eligible Medi-Cal and California Children's Services (CCS) members. California Code of Regulations, Title 22, Section 51223(c) defines a "qualified orthodontist" as a dentist who "confines his/her practice to the specialty of orthodontics, and, who either has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association" or "who has completed advanced training in orthodontics prior to July 1, 1969 and is a member of, or eligible for membership in the American Association of Orthodontists."

Enrollment and Orthodontic Certification

1. A provider must be actively enrolled as a Medi-Cal dental provider to qualify for participation in this program. An orthodontist who wishes to submit claims for services provided to eligible Medi-Cal Dental and/or CCS members must first complete an Orthodontia Provider Certification form. For an enrollment application and information, call the Medi-Cal Dental Telephone Service Center at (800) 423-0507.
2. Complete the Orthodontia Provider Certification form and return it promptly to Medi-Cal Dental. Medi-Cal Dental will enter an appropriate code on an automated provider record to establish and identify the provider under the Orthodontic Services Program.

3. The provider will be notified in writing when the certification has been approved**. Orthodontic services provided to Medi-Cal members prior to an approved certification will not be paid by Medi-Cal Dental**.
4. Medi-Cal Dental will furnish an initial supply of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheets (DC016) upon certification approval. Additional Score Sheets may be obtained through the Medi-Cal Dental forms supplier by checking the appropriate box on the Medi-Cal Dental Forms Reorder Request.

Initial Orthodontic Evaluation and Completion of the HLD Index Score Sheet

An initial orthodontic examination called the Limited Oral Evaluation (Procedure D0140) must be conducted. This examination includes completion of the HLD Score Sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the patient qualifies for medically necessary orthodontic services. Follow the instructions on the back of the form to assess the medical necessity (example in "Section 6: Forms" of this Handbook). The qualifying conditions for treatment under the Medi-Cal Dental Orthodontic Program are:

1. Cleft palate deformities.
2. Craniofacial anomaly. (A description of the condition from a credentialed specialist must be attached.)
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite under the Orthodontic Services Program.)
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with reported masticatory and speech difficulties. Submit photographs for this exception.

6B. Individual score of at least 26 points.

Children who do not meet the Manual of Criteria requirements for orthodontic services may still be covered if services are documented as medically necessary under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Regulations. Attach the required supporting documentation in addition to completing the "conditions" section of the form. Refer to the EPSDT Services Request for Orthodontic Services of this section for clarification of qualifying factors for EPSDT services.

If one of the above conditions is present, Diagnostic Casts (Procedure D0470) may be provided for members. (Note: Diagnostic Casts are payable only upon authorization of orthodontic treatment plan.)

The Orthodontic Evaluation (Procedure D0140) and/or the Diagnostic Casts (Procedure D0470) do not require prior authorization from Medi-Cal Dental. Please note that all other orthodontic services do require prior authorization.

Diagnostic Casts

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

Craniofacial 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. Casts should be completely dry to prevent mold from forming. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

Careful packaging will help ensure that the casts arrive at Medi-Cal Dental in good condition. Medi-Cal Dental receives many broken and damaged casts due to poor packaging. Casts that have been broken or damaged due to poor packaging cannot be used for processing and will be destroyed. If Medi-Cal Dental receives broken or damaged casts, a Resubmission Turnaround Document (RTD) will be initiated to request new casts, causing further 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.

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 patient’s name,
- Client Index Number (CIN) or Benefits Identification Card (BIC) number,
- Billing Provider Name, and
- Service office National Provider Identifier (NPI) number.

If the casts are received without patient identification and billing provider information, they will be destroyed.

Only duplicate or second pour diagnostic casts should be sent to 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 the provider to request a reevaluation.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for the diagnostic casts, the RTD requesting the diagnostic casts, or the TAR for orthodontic treatment. The diagnostic casts should be packaged separately and mailed to Medi-Cal Dental approximately 10 days prior to mailing the claim, the RTD, or the TAR to the address on the TAR/Claim form. Unless otherwise directed, do not send casts to alternate addresses as they can be misdirected or lost. **Providers must keep diagnostic casts for a minimum of two years after the case is completed.**

Clarification of Case Types

Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If a malocclusion case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photographs and documentation.

Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition phase, and again in the permanent dentition phase. If the cleft palate cannot be demonstrated on the diagnostic casts, 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 photographs 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 photographs 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 photographs 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 the permanent dentition phase. Documentation from

a credentialed specialist is required for all craniofacial anomaly cases. Submission of the diagnostic casts is optional.

Procedure D8660 – Pre-orthodontic Treatment Visits (maximum of 6 quarters) are optional and are a benefit only for craniofacial anomaly cases to monitor the patient's dentition and/or facial growth prior to starting orthodontic treatment.

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 photographs 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 photographs 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 photographs 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.

Orthodontic Treatment Plans

1. A complete orthodontic treatment plan must be submitted to request prior authorization. The orthodontic treatment plan must include:
   a) TAR:
      - Comprehensive orthodontic treatment of the adolescent dentition (D8080)
      - Periodic orthodontic treatment visit(s) (D8670)
      - Note: Document the case type and dentition phase in the comment section (box 34).
      - Orthodontic retention (D8680)
      - Any necessary radiographs such as complete series (D0210) or Panoramic radiographic image (D0330), and cephalometric radiographic images (D0340) should also be requested on the TAR.
   b) HLD Score Sheet
   c) Diagnostic Casts

   Note: For craniofacial anomalies cases only: If Pre-orthodontic treatment visits (Procedure D8660) are necessary prior to starting orthodontic treatment, indicate the quantity and attach all appropriate documentation to the TAR for the complete orthodontic treatment plan.

2. The Medi-Cal dental orthodontic consultant will evaluate the HLD Score Sheet, and the diagnostic casts or documentation (as applicable for cleft palate and craniofacial anomaly

cases) to determine if the case qualifies for treatment under the Medi-Cal dental guidelines for orthodontic services.

Treatment Plan Authorization and Payment Submission Procedures

1. When the TAR for orthodontic services is approved by Medi-Cal Dental, a series of Notices of Authorization (NOAs) will be issued confirming authorization. NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. A calendar quarter is defined as:
   a) January through March
   b) April through June
   c) July through September
   d) October through December

   These NOAs should be used for billing purposes.

2. Each calendar quarter when services are provided, submit one NOA to Medi-Cal Dental for payment.

   Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080).

   Note: On or after July 1, 2008, each incidence of Procedure D8670 will be paid once per quarter. Only one NOA with a date of service in a given quarter needs to be submitted in order to receive the quarterly payment. Treatment visits may occur at any frequency deemed necessary during the quarter to complete the active phase of treatment, e.g., monthly, bimonthly, quarterly.

   NOAs 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 subject to patient eligibility.

   Note: If payment of an NOA is denied, submit a Claim Inquiry Form (CIF) for reevaluation. Do not resubmit for the same date of service using a new NOA.

3. Request a reevaluation for prior authorization of treatment only on a denied NOA for the orthodontic treatment plan. NOAs for the active phase of treatment and retention may not be reevaluated.
4. Under the Medi-Cal Dental orthodontic program, confirmation of continued treatment is required at the end of each 12 months of authorized treatment. Medi-Cal Dental will send a Resubmission Turnaround Document (RTD) requesting a signature to confirm continued treatment for the subsequent 12 months or remaining treatment. Indicate treatment will continue by signing the RTD. If the RTD is not returned according to Medi-Cal dental policies, the request for continued treatment will be disallowed. A new TAR must then be submitted for all remaining treatments.

Helpful Hints

The following is important information regarding eligibility when providing orthodontic treatment:

Member eligibility must be current for each month and must cover orthodontic benefits.

A member seeking orthodontic treatment may have a SOC obligation to meet each month.

A member may have coverage under another plan that includes orthodontic services. Members with other dental coverage must still have orthodontic services authorized under Medi-Cal Dental.

Each request for payment must have the Explanation of Benefits (EOB), fee schedule, or letter of denial attached.

The information may state that the member is enrolled in a special project or prepaid health plan that includes orthodontic treatment. Refer to "Section 7: Codes" of this Handbook for additional information and a list of current special project codes and prepaid health plan codes.

Refer to "Section 4: Treating Members" of this Handbook for complete information on member eligibility and procedures for verifying eligibility.

Transfer Cases

When transferring from one certified Medi-Cal dental orthodontist to another certified Medi-Cal dental orthodontist, prior authorization is necessary before continuing treatment.

Transfer of a case in progress by another carrier also requires prior authorization.

Original diagnostic casts, along with new casts or progress photographs and any other documentation must be submitted for evaluation.

Diagnostic casts are not required if the treatment has already been approved by Medi-Cal Dental.

Only orthodontic cases that meet the program criteria will be authorized for the remaining treatment which will be determined by the Medi-Cal dental orthodontic consultant.

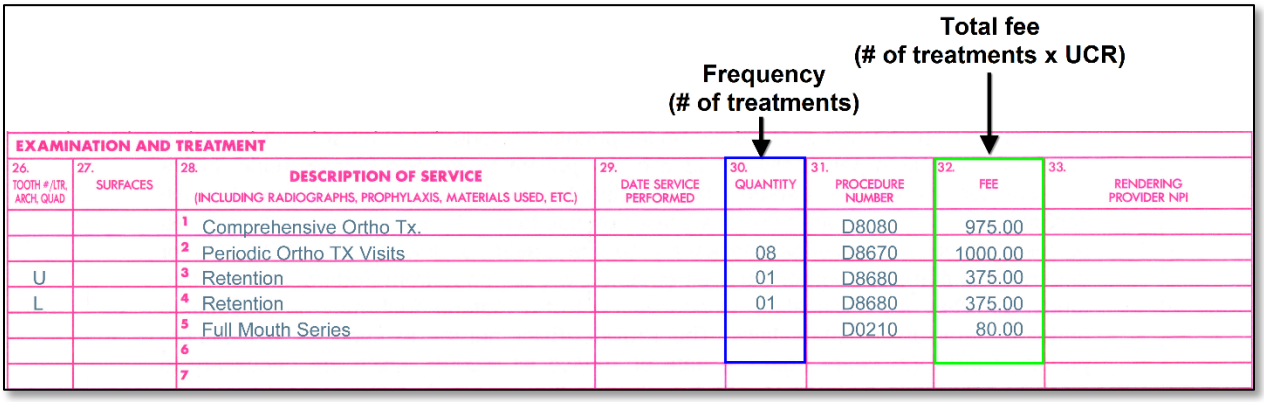
Treatment Plan Authorization and Payment Submission Procedures

When additional orthodontic services are required or there is a change in the authorized treatment plan, submit a new TAR with documentation and any NOAs that have not been used. Mark all unused NOAs for deletion.

- If the orthodontic treatment is completed in less time than originally authorized, then document this on the NOA for the final quarterly visit.

- If there are remaining NOAs for quarterly visits but there is no NOA for retainers, then submit all the outstanding NOAs for deletion and attach a new TAR for upper and lower retainers along with the request for payment.
- If billing on the NOA for the retainers, then document that the treatment has been completed ahead of schedule and attach any remaining NOAs for deletion.
- When a new TAR is authorized by Medi-Cal Dental, the provider will receive a series of NOAs confirming the authorization. Use the new NOAs for billing purposes.

The TAR submitted for Procedures D8670 and D8660 must list the total quantity or frequency (number of quarters necessary to complete the treatment) in the "Quantity" field, column #30 and the total fee (fee for the procedure times the number of quarters) in the "Fee" field, column #32. The example above shows the correct way to list these procedures to ensure accurate calculation of the Notice of Authorization.



EXAMINATION AND TREATMENT							
26. TOOTH #/LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Comprehensive Ortho Tx.			D8080	975.00	
		2 Periodic Ortho TX Visits		08	D8670	1000.00	
U		3 Retention		01	D8680	375.00	
L		4 Retention		01	D8680	375.00	
		5 Full Mouth Series			D0210	80.00	
		6					
		7					

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

In accordance with the requirements in Section 1905(r) of the Social Security Act and Title 42 Code of Federal Regulations Section 441.50 et seq, and specifically CFR 441.56(b)(1)(vi), the Department of Health Care Services (DHCS) is responsible for providing full-scope Medi-Cal members under the age of 21 with a comprehensive, high-quality array of preventive (such as screening), diagnostic, and treatment services under EPSDT. Further, consistent with state and federal law and regulations for EPSDT, the Medi-Cal Dental Program covers all services that are medically necessary under EPSDT, including those to "correct or ameliorate" defects and physical and mental illness or conditions. These services are without cost for the member.

EPSDT: Frequently Asked Questions

What is EPSDT?

The EPSDT benefit allows Medi-Cal enrolled children and youth under age 21 to get preventive (screening) dental services and to get diagnostic and treatment services that are medically necessary to correct or ameliorate health conditions found during screening.

What kind of dental services are classified as EPSDT?

EPSDT services are Medicaid-covered services that are medically necessary. These services may or may not be part of the Manual of Criteria.

What is the EPSDT standard for "medically necessity?"

The EPSDT benefit entitles enrolled members under the age of 21 to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in the SSA, Section 1905(a), regardless of whether or not the service is covered under the Medi-Cal State Plan or is listed in the Manual of Criteria, if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions, meaning that the service is medically necessary under EPSDT. Effective January 1, 2019, Welfare and Institutions Code section 14059.5 distinguishes the definition of medical necessity for individuals 21 and older compared with the definition for those under 21. For individuals younger than 21 years of age, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable."

Medi-Cal members under age 21 may require dental services that are not part of the current Medi-Cal dental scope of benefits. Conversely, the dental service may be part of the Medi-Cal dental scope of benefits for adult members but not for members under the age of 21, or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by
Medi-Cal Dental. In these cases, the child member may still be eligible for these services based upon submitted documentation that demonstrates the medical necessity to correct or ameliorate the child's condition.

When is a Treatment Authorization Request (TAR) required for EPSDT services?

Providers must submit a TAR when a member under the age 21 needs an EPSDT medically necessary service, such as a service to correct or ameliorate (make tolerable) an identified condition, if that service otherwise would not be covered by Medi-Cal Dental. Examples of when a TAR is required include:

1. To perform a dental procedure that is not listed in the Manual of Criteria:
   - Providers should use the appropriate Current Dental Terminology (CDT) procedure code. Providers should not limit their comments to Field 34 of the TAR/Claim form but

submit all documents that are needed to describe and support the medical necessity for the requested service(s).

Example: Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive. With adequate documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT service.

2. To perform a dental procedure that is listed in the Manual of Criteria when the member under the age of 21 does not meet the published criteria:
   - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition.

Example 1: John S. (age 17) has a craniofacial anomaly with multiple edentulous areas. The edentulous areas cannot be adequately restored using conventional prosthetics – an implant-retained fixed prosthesis may be authorized as an EPSDT service.

Example 2: Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planning. The Manual of Criteria states this procedure is not a benefit for patients under 13 years of age. However, as a documented medically necessary periodontal procedure, it may be authorized as an EPSDT service when there is radiographic evidence of bone loss.

3. To perform a dental procedure when the member under the age of 21 needs a dental service more frequently than is specified in the Manual of Criteria:
   - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition.

What if the procedure has already been rendered and a TAR was not submitted?

In a situation where a TAR was not submitted for a procedure in which an EPSDT medically necessary service was needed, the provider shall submit a claim with all documentation to support the medical necessity. The provider shall also indicate the reason that a TAR was not submitted.

What should I tell my patients about EPSDT?

Using both written materials and in person or over the phone dialogue, dental providers should inform Medi-Cal members under age 21, or their parents, about EPSDT benefits and services and how to access them. Providers should tell eligible patients and their families about all the following:

- The value of preventive services and screenings.
- The services available under EPSDT.
- Where and how to obtain EPSDT services.

- EPSDT services are free to eligible individuals under age 21.

Are dental services to resolve medical conditions covered under EPSDT?

In some cases, dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech defect or disorder cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the TAR/Claim form.

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.

Are orthodontic services covered under EPSDT?

A TAR for orthodontic services when the child or youth under the age of 21 does not have one of the six automatic qualifying conditions or does not score 26 points or above, must include a completed Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet (DC-016 09/18) in addition to other documentation requirements listed in the Manual of Criteria. The review of active orthodontic services also requires the submission of diagnostic casts.

The provider is required to submit all documentation required for the procedure per the Manual of Criteria and the clinical information required to determine medical necessity under EPSDT guidelines.

What kind of clinical information does Medi-Cal Dental need to determine the medical necessity?

Providers must consult the Manual of Criteria, to identify the documentation and clinical information required for submittal to determine medical necessity under EPSDT guidelines.

Whom can I call to obtain further information about the EPSDT requirements under Medi-Cal?

Please call the Telephone Service Center at
(800) 423-0507 for any questions or to obtain more information regarding EPSDT services.

Non-Emergency Medical Transportation (NEMT)

Medi-Cal Dental provides non-emergency transportation services to eligible Medi-Cal members. Members can request transportation from their homes to their appointed dental locations or other facilities; however, such requests are only approved for recipients who are eligible for Medi-Cal on the date of service and whose physicians or dentists have demonstrated medical necessity through prior authorization. Adjudication of claims will be subject to prior authorization and will be approved when the recipient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and the transportation is required for the purpose of obtaining necessary health care covered by the Medi-Cal program.

Medi-Cal dental providers are authorized to contact NEMT providers and submit all requests to transportation companies. The transportation company will then submit a TAR to the Department of Health Care Services (DHCS), Clinical Assurance and Administrative Support Division (CAASD), who will review and approve the TAR if medical necessity is demonstrated.

Please note that NEMT necessary for obtaining medical services is covered but subject to the written prescription of a physician or dentist.

Medi-Cal dental providers are responsible for the submission of the Nonemergency Medical Transportation (NEMT) Required Justification form (DHCS 6182) to the pre-designated transportation companies and every TAR must be accompanied by a legible prescription or order sheet signed by the physician or dentist for the member. The prescription requirements must include the following:

1. Purpose of the trip
2. Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation
3. Medical or physical condition that makes normal public or private transportation inadvisable

Note: When transportation is requested on an ongoing basis, the chronic nature of a recipient’s medical or physical condition must be indicated and a treatment plan from the physician or therapist must be included. A diagnosis alone, such as “multiple sclerosis” or “stroke,” will not satisfy this requirement.

The Medi-Cal field office consultant needs the above information to determine the medical necessity of a specialized medical transport vehicle and the purpose of the trip. Incomplete information will delay approval.

Medi-Cal Dental has provided a list of pre-designated transportation companies in each county for dental providers to contact. Providers are encouraged to refer to work with the NEMT companies if dental providers have questions.

A list of approved NEMT providers is attached to bulletin Volume 31, Number 8.

Non-Medical Transportation (NMT)

Pursuant to Welfare and Institutions Code (W&I Code) Section 14132 (ad) (1), effective for dates of service on or after July 1, 2018, non-medical transportation (NMT) is a covered Medi-Cal benefit, subject to utilization controls and permissible time and distance standards, for a member to obtain covered Medi-Cal services. The NMT benefit is eligible full-scope Medi-Cal fee-for-service members and pregnant women during pregnancy and for 12 months postpartum, including any remaining days in the month in which the last postpartum day falls. NMT includes transporting recipients to and from Medi-Cal covered medical, mental health, substance abuse, or dental services. Members enrolled in a Medi-Cal managed care health plan must request NMT services through their Member Services.

W&I Code 14132 (ad)(2)(A)(i) defines NMT as including, at minimum, round trip transportation for a recipient to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance. NMT services are a benefit only from an enrolled NMT Provider.

NMT does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated recipients by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations, since these would be covered as non-emergency medical transportation (NEMT) services. For more details and information on eligibility for NMT/NEMT services, refer to the guide located here.

Please visit the Medi-Cal Dental website here to assist your patients with information about their qualifying appointment(s).