Quick Reference for Medi-Cal Dental Providers

(This is a summary of key information and requirements of the Medi-Cal Dental Program. This document does not replace the detailed information in the Medi-Cal Dental Provider Handbook.)

I. PROCESSING A MEDI-CAL MEMBER THROUGH THE DENTAL PRACTICE

Above all: The treating provider must be enrolled as a Medi-Cal Dental provider

- The first criterion for treating Medi-Cal members is to assure that every dentist in the office providing care to a Medi-Cal member is enrolled in the Medi-Cal Dental Program.
- Enrollment applies to both "billing providers" (i.e., the entity billing Medi-Cal Dental for services) and "rendering providers" (i.e., any associate treating a Medi-Cal member).
- **DO NOT HAVE A NON-ENROLLED DENTIST TREAT MEDI-CAL MEMBERS…EVER!**
- See **Section 3**, *Enrollment Requirements*, of the "Medi-Cal Dental Provider Handbook" (Provider Handbook).
- In order for an office to have multiple providers, the practice must be enrolled as a group location.

Verifying member eligibility:

- Make a copy of the member's Medi-Cal Benefits Identification Card (BIC). However, please note that dental offices may verify eligibility using the Medi-Cal Automated Eligibility Verification System (AEVS), or the Medi-Cal website, and may, with the member's approval, use the member's Social Security Number (SSN) to verify eligibility. For more information regarding ways to verify member identification and eligibility, please refer to **Section 4** of the Provider Handbook or provider bulletin article.
- Verify and copy the member's photo identification. Photo identification is not required for members who are 17 years old and younger.
- Member eligibility should be verified one time each month that services are provided. Eligibility may be verified electronically using the Medi-Cal website here or by calling the AEVS at 1-800-456-2387.

Required Member Information:

- Please ensure that the radiographs taken reflect, "What you saw when you made the diagnosis". Take necessary radiographs when making a diagnosis, so the Medi-Cal Dental program can see how your radiograph(s) help to substantiate your diagnosis.
- Radiographs are part of the member's clinical record and the original images should be retained by the dentist. Radiographs and photographs will not be returned.
- Intraoral photographs of teeth are required on all occlusal, buccal, lingual tooth surfaces to document caries not seen on radiographs, or for any other clinical situations you may need to demonstrate.
- Radiographs are required to justify medical necessity when prior-authorizing scaling and root planing, crowns, dentures and root canal therapy.
- All periodontal procedures require submission of radiographs. Keep the periodontal chart for your record; however, submittal is not required.
- Maintain the originals of all radiographs, photos, and notes you send to the Medi-Cal Dental Program for your own records.

What is Covered:

- All covered Medi-Cal Dental benefits, with diagnostic policies and documentation requirements, are in Section 5, *Manual of Criteria (MOC) and Schedule of Maximum Allowances,* of the Provider Handbook. Updates to the MOC can be located at the beginning of section 5 page titled Policy Changes.
- Common procedures –examinations, prophylaxis, amalgam and composite fillings, stainless steel crowns, pulpotomies, space maintainers, dental sealants, and all emergency procedures – are paid without prior authorization.
- Note policies on covered orthodontic procedures, and orthodontic procedures requiring prior authorization in section 2 of the Provider Handbook.
- Prior authorization is needed for root canal therapy age 21 and older, cast crowns all ages, and is recommended for extraction of third molars.
- For further clarification on -Medi-Cal Dental's policy on third molar extraction, see *the Oral & Maxillofacial Surgery General Policies* in section 5 of the Provider Handbook.
- Pregnant and post-partum women will receive all dental procedures listed in the Manual of Criteria, as long as they meet the required criteria, see **Section 5**, *Manual of Criteria and Schedule of Maximum Allowances,* of the Provider Handbook for criteria.

II. MEDI-CAL DENTAL BILLING PROCESS

Use of the TAR/Claim form:

- The Treatment Authorization Request (TAR)/Claim form is a single form used to request prior authorization of treatment from the Medi-Cal Dental program, and to file claims for reimbursement for services.
- See section 2 of the Provider Handbook for a list of procedures requiring prior authorization.
- See section 6 of the Provider Handbook for information on the TAR/Claim form.
- See section 6 of the Provider Handbook for a checklist of information that should be provided on the claim forms.

Submitted claim form:

The Medi-Cal Dental program will respond to a submitted claim in one of two ways:

- It will either pay or deny payment for the service and communicate the payment decision to the dentist through the Explanation of Benefits (EOB) form.

…**or**…

- It will issue a "Resubmission Turnaround Document" (RTD) form requesting additional information necessary to process the claim.

Explanation of Benefits (EOB):

- Provides details of what was paid and what was denied on a submitted claim.
- EOBs are issued as part of a bulk payment each week and lists claims that have been in process over 18 days.
- Denials are assigned an Adjudication Reason Code indicating why a denial was made. These codes are included on the EOB. See section **7**, *Codes* of the Provider Handbook for listing of denial codes.
- See section 6 of the Provider Handbook for more information on the EOB.

Resubmission Turnaround Document (RTD):

- Itemizes the additional information that the Medi-Cal Dental program needs to process a submitted claim or request for prior authorization.
- The dentist has 45 days from the date the RTD was issued to provide the requested information to the Medi-Cal Dental program.
- See section 6 of the Provider Handbook for information on the RTD.
- See section 7 of the Provider Handbook for RTD codes and messages.

Avoiding authorization and claim denials:

On both TARs and claims:

- Assure that radiographs, if required, are of diagnostic quality and show what you are seeing as needing treatment.
- Assure that photographs are being submitted to support the procedure being claimed.
- Assure that radiographs and photographs are properly labeled per the Diagnostic General Policies in section 5 of the Provider Handbook.
- Consider whether radiographs submitted for payment of restorations demonstrate the restoration was medically necessary.
- Attach treatment notes or other written documentation to show medical necessity of procedures claimed.
- Check the claim form to ensure all required information has been entered, and that the form is signed by the individual completing the form. Medi-Cal Dental forms must be signed in blue or black ink.

Common reasons for claim denials:

- Incomplete or non-submission of necessary radiographs, photographs, or written documentation.
- Claims and documentation that fail to show treatment was medically necessary.
- Radiographs and photographs are not properly labeled or of non-diagnostic
- Clerical errors such as failure to enter dates of service, failure to include treating NPI, or failure to sign claim form.

Using a Notice of Authorization (NOA) form for Prior Authorized Treatment:

- TARs submitted for prior authorization of treatment will generate a NOA form. Completed NOA is required to be submitted to Medi-Cal Dental when treatment is completed.
- See section 6 of the Provider Handbook for more information on the NOA.
- Authorization does not guarantee payment. Payment is subject to member's eligibility at the time service is rendered.

If a Claim is Denied:

- When a claim or request for prior authorization is denied, check the adjudication reason code for the denial, found -in section 7 of the Provider Handbook. When an entire document is denied, refer to the TAR/Claim Policy Codes and Messages, found in section 7 of the Provider Handbook.
- Denials referenced on an EOB may be rebilled using a Claim Inquiry Form (CIF – see section 6 of the Provider Handbook).
- If in response to a CIF, Medi-Cal Dental upholds the original denial, a provider may request a formal "First Level Appeal." (See section 2 of the Provider Handbook on both the CIF process and First Level Appeals.)

The Medi-Cal Dental program provides direct assistance to dentists:

If you need live assistance on anything related to claim documentation, patient eligibility, covered benefits, call the Medi-Cal Dental Telephone Service Center at 1-800-423-0507.