California Medi-Cal Dental Advanced Seminar Packet

Version 2.0

Effective Date: 05/06/2026

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

Dear Medi-Cal Dental Provider and Staff:

Welcome! This seminar has been designed for dental providers and office staff who participate in California Medi-Cal Dental.

The material contained in the training packet has been prepared to help familiarize you with the Medi-Cal Dental's policies, procedures, and billing requirements. You should also refer to the Medi-Cal Dental Provider Handbook, located on Medi-Cal Dental website at www.dental.dhcs.ca.gov for additional information.

We hope that you will benefit from the information presented at today's seminar. If you have any questions, please call our provider toll-free line at (800) 423-0507.

Sincerely,

Medi-Cal Dental

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1 Introduction

This packet provides additional information about the advanced training seminar. For detailed, step-by-step instructions on completing each form, please refer to the Medi-Cal Dental Provider Handbook. The seminar packet also includes adjudication reason codes; you can find these codes, along with their detailed descriptions, in Section 7 of the Provider Handbook to help familiarize yourself with them.

Training and Education	Billing and Payment
Free statewide seminars offering Continuing Education (CE) credits for attendees	Electronic deposit of Medi-Cal Dental payment checks directly into a bank account assures timely availability of funds
A Toll-free Telephone Service Center (TSC) to quickly answer inquiries on a variety of topics	Automated processing and faster payment of more Medi-Cal Dental claims due to simplified prior authorization and billing requirements
Outreach activities designed to distribute Medi-Cal Dental education and promote dentist access in all areas of California	All billing forms needed for Medi-Cal Dental processing are free of charge and are sent directly to the provider’s office
Participating providers may access the Provider Handbook (a comprehensive manual), monthly bulletins and other informational materials directly from the Medi-Cal Dental website at www.dental.dhcs.ca.gov	The ability to submit billing forms, radiographs and attachments electronically through Medi-Cal Dental's Electronic Data Interchange (EDI)

1.1 Resource Links

1. CA Department of Public Health (Verify Health Care Facilities)
2. California Dental Association (CDA)
3. CalAIM Website
4. California Business and Professions Code – Dental Practice Act
5. California Code of Regulations, Title 22
6. California's Medicaid State Plan (Title XIX)
7. Caries Risk Assessment (CRA) Form for Children
8. Case Management Referral Form
9. Care Coordination Form
10. Department of Health Care Services (DHCS) Website
11. DHCS 6213 Caries Risk Assessment Attestation Form
12. Language Tagline Sign
13. Learning Management System (LMS)33
14. Medi-Cal County Office Directory
15. Medi-Cal Dental Community Health Workers (CHW)
16. Medi-Cal Dental Forms Reorder Request
17. Medi-Cal Dental Provider Handbook
18. Medi-Cal Dental Provider Bulletins (Current Year)
19. Medi-Cal Dental Provider Archive Bulletins (Previous Years)
20. Medi-Cal Dental Provider Portal (History, Claims, etc.)
21. Medi-Cal Dental (Smile California)
22. Medi-Cal Dental Website
23. Medi-Cal Website (Member Eligibility)
24. Provider Application and Validation for Enrollment (PAVE)
25. Provider Enrollment Division (PED) Message Center
26. Treating Young Kids Everyday (TYKE) Training
27. Working Disabled Program

2 Medi-Cal Dental Overview

The primary objective of Medi-Cal Dental is to create a better dental care system and increase the quality of services available to individuals and families who rely on public assistance to help meet their health care needs. Through expanding participation by the dental community and efficient, cost-effective administration of Medi-Cal Dental, the goal to provide quality dental care to Medi-Cal members continues to be achieved.

Medi-Cal Dental Background

- Medi-Cal Dental is governed by policies subject to the laws and regulations of the:
  - Welfare and Institutions (W&I) Code
  - California Code of Regulations (CCR), Title 22
  - California Business and Professions Code – Dental Practice Act
    - https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Statutes_And_Regulations/StatutesAndRegulations.
  - California's Medicaid State Plan (Title XIX)
    - https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

Requirements for Providers

- Medi-Cal providers must ensure that all their rendering providers are enrolled in Medi-Cal Dental prior to treating Medi-Cal Dental members
  - Rendering providers must be associated to the service office location
- Payments made to Medi-Cal providers for services performed by their unenrolled rendering providers will be subject to payment recovery

See Bulletin Provider Handbook Section 3 (Enrollment Requirements) for more information

Record Keeping Criteria for Medi-Cal Dental

- Complete members treatment records shall be retained for 10 years from the date the service was rendered and must be readily retrievable upon request
- Emergency services must have written documentation which includes, but is not limited to:
  - The tooth/area, condition and specific treatment performed
  - The statement: "An emergency existed" is NOT sufficient
- Records shall include documentation supporting each procedure provided including, but not limited to:
  - Type and extent of services, and/or radiographs demonstrating and supporting the need for each procedure provided
  - Type of materials used – bands, brackets, aligners, etc.
  - Impressions/scans, etc.
  - The date and ID of the enrolled provider who performed the treatment

Click here or see the California Code of Regulations, Title 22 for more information.
Also, See section 8 of the Provider Handbook regarding record keeping

Record Keeping Criteria

- Medi-Cal Dental submission requirements for prior authorization or payment purposes may differ from the requirements of the Dental Practice Act or the Standard of Care.
- For example, a D7140 does not require submission of a radiograph to Medi-Cal Dental for payment purposes but per the standard of care, a radiograph must be part of the patient record.

Senate Bill 639

- Enhanced protections for Medi-Cal members
- Contains provisions regarding lines of credit between a provider and member
- Written treatment plan requirement:
  - Must indicate if Medi-Cal would cover an alternate medically necessary service
  - Must notify the Medi-Cal member that they have the right to ask for only services covered by Medi-Cal
  - The dentist must follow Medi-Cal rules to secure Medi-Cal covered services before treatment is rendered

See Bulletin Volume 42, Number 03 (February 2026) for more information
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_42_Number_03.pdf

Upcoding

- Upcoding means billing for more surfaces than were actually restored or for billing for more complex procedures than were performed
  - Billing D7210 when the tooth was extracted without laying a flap and performing ostectomy and/or tooth sectioning is an example of upcoding.
- Provider Bulletin Volume 33, Number 2 (February 2017) reminds providers to avoid upcoding

See Provider Handbook Section 8 (Fraud, Abuse, and Quality of Care) for more information

3 Enrollment

3.1 Provider Participation in California Medi-Cal Dental

To receive payment for dental services rendered to Medi-Cal members, prospective providers must apply and be approved by Medi-Cal Dental to participate in Medi-Cal Dental. When a provider is enrolled in Medi-Cal Dental, Medi-Cal Dental sends the provider a letter confirming the provider's enrollment effective date.

Medi-Cal Dental will not pay for services until the provider is actively enrolled in

Medi-Cal Dental. Refer to the Provider Handbook Section 3 (Enrollment Requirements) for more information.

3.1.1 PAVE Portal

The PAVE portal is a web-based application that allows dental providers to submit enrollment applications and required documentation to DHCS electronically.

NOTE: Paper applications are not accepted and will be returned.

All dental providers must:

- Use PAVE e-forms to enroll in Medi-Cal.
- Report changes to current enrollments within thirty-five (35) days of the change to license, address, etc.
- Complete revalidation or continued enrollment for individual, group, and rendering provider types.
- Providers may terminate their participation in Medi-Cal Dental at any time using the PAVE portal.

3.1.2 Enrollment Assistance

For Medi-Cal provider enrollment information, contact the Provider Enrollment Division (PED) using the Inquiry Form on PED's website under Provider Resources.

- https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Providers can also contact the PED's Message Center:

- Phone Number (916) 323-1945

- For application questions complete: Online Inquiry Form
- https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Contact-List.aspx
- Send a message in PAVE

PAVE Technical Support (excluding State holidays)

For PAVE technical support, please call the PAVE Help Desk at (866) 252-1949.

- Help Desk is available Monday-Friday from 8:00 am – 6:00pm

PAVE Chat feature (excluding State holidays)

Providers can also use the PAVE Chat feature for support while in PAVE.

- Chat is available Monday-Friday from 8:00 am – 4:00 pm

NOTE: All dental providers under the enrolled billing provider are required to be enrolled as rendering providers in Medi-Cal Dental, prior to performing services on Medi-Cal Dental members.

3.1.3 Suspended and Ineligible Providers

Billing providers who submit claims for services provided by a rendering provider suspended from participating in Medi-Cal Dental are also subject to suspension from the Medi-Cal Dental.

Welfare and Institutions (W & I) Code, §14043.61(a) states that “a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal for the services, goods, supplies, or merchandise provided, directly, or indirectly, to a Medi-Cal member, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal and the individual or entity is listed on either the Suspended and Ineligible Provider List,…or any list is published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid, to identify suspended, excluded, or otherwise ineligible providers.”

3.2 Customer Service

3.2.1 Medi-Cal Dental Referral System

Helps to increase the patient base by connecting providers with Medi-Cal members who need dental care.

3.2.2 Telephone Service Center (TSC)

A special toll-free telephone line with friendly, knowledgeable agents to answer questions about Medi-Cal Dental. The provider toll free number is (800) 423-0507. Agents are available Monday through Friday 8:00 am to 5:00 pm.

3.2.3 State of the Art Virtual Agent- Gabby

The Medi-Cal Dental virtual agent, referred to as Gabby, is an automated inquiry system for use by providers.

The menu options that do not require entering a provider number include:

- Billing criteria for procedures most frequently inquired about by providers
- Upcoming schedule of provider seminars for the caller's area
- A monthly news flash consisting of items of interest to providers
- Information about ordering Medi-Cal Dental forms
- Information about enrollment in Medi-Cal Dental
- Transfer to the Telephone Service Center for further inquiry

The menu options that do require entering a provider number include:

- Patient history relative to specific service limited procedures
- Status of outstanding claims and/or TARs that the caller has submitted
- Provider financial information (next check amount and net earnings for the current or previous year)

3.2.4 Onsite Visit

Provider Field Representatives are available for onsite visits to assist providers with policy or billing issues that cannot be resolved by telephone or written correspondence. Medi-Cal Dental will determine the necessity to schedule an onsite training visit. To request a visit please contact the Telephone Service Center at (800) 423-0507.

4 Case Management/Care Coordination

Case Management

- Designed for members with special health care needs who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers
- Examples of special health care needs include:
  - Physical
  - Developmental
  - Mental
  - Sensory
  - Behavioral
  - Cognitive or emotional impairment
  - Or some limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs

Case Management

- Referrals for Case Management services are initiated by:
  - The Medi-Cal member's Medi-Cal provider and based on a current, comprehensive evaluation and treatment plan
  - Medical provider or other healthcare professional
  - Social Worker
- Case Management referral form is located on the Medi-Cal Dental website:
  - The referral form is located under the "**Dental Case Management Referral Form**" link (see link below); this qualifies as a referral once completed
  - Referral forms are not accepted by mail

https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Dental_Case_Management/DentalCaseManagementReferral

Care Coordination

Medi-Cal Members can contact the Telephone Service Center and request Care Coordination assistance for dental services such as:

- Locating a general dental or specialist
- Accessing appointments
- Translation services
- Transportation assistance

» Care Coordination referral form is also located on the Medi-Cal Dental website:

- The referral form is available under the "**Care Coordination Referral Form**" link (see link below); this qualifies as a referral once completed
- Referral forms are not accepted by mail

https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/CareCoordinationReferralForm

American Sign Language (ASL) and Language Services

» **ASL assistance** – available via telephone during or scheduled in advance for the appointment

» **Language interpreters** – available in 250 languages and dialects via telephone

» **Free language tagline signs** – available for providers / members with limited English

www.smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

All providers and members can request these free ASL translation and language services and other assistance by calling the Telephone Service Center

Language Assistance Services

- **Provider Line -** to request a translator for a member:
  - **800-423-0507** (Mon-Fri 8am-5pm)
- **Member Line -** to request a translator:
  - **800-322-6384** (Mon-Fri 8am-5pm)
- **Member TDD/ TTY Lines -** for Hearing or Speaking Limitations:
  - Teletext Typewriter (TTY) at **800-735-2922** (Mon-Fri 8am-5pm)
  - California Relay Service (TDD/TTY) at **711** (After Mon-Fri 8am-5pm business hours)

See the Provider Handbook Section 4 (Treating Members) for more information.

4.1 Phone Numbers and Websites

Provider Toll-Free Line (Medi-Cal Dental)	800-423-0507
Medi-Cal Dental Website	www.dental.dhcs.ca.gov
Member Toll-Free Line (Medi-Cal Dental)	800-322-6384
Member Website	www.smilecalifornia.org
A.E.V.S. (to verify member eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S./Internet Help Desk	800-541-5555
Medi-Cal Website (to verify member eligibility)	mcweb.apps.prd.cammis.medi-cal.ca.gov/
EDI Technical Support	800-423-0507
Medi-Cal Dental Forms (fax number)	877-401-7534
Health Care Options	800-430-4263

CA Department of Public Health website:

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx

NOTE:

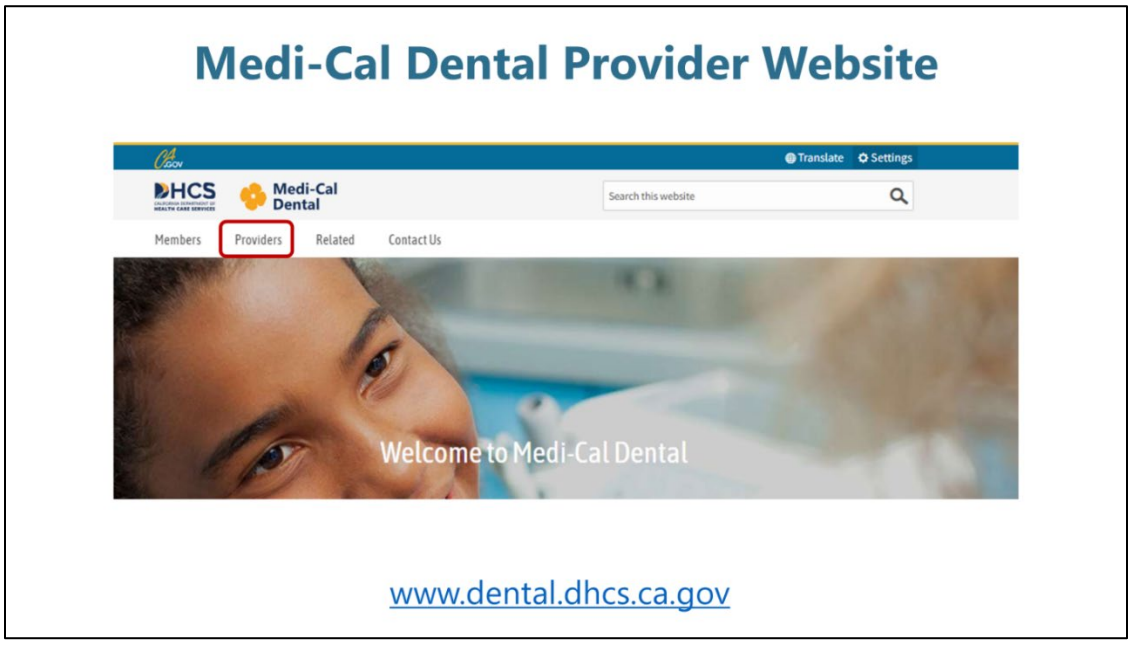
- Members may call the P.O.S./Internet Help Desk to remove other health care coverage.
- Members may call the Health Care Options number to change managed care.

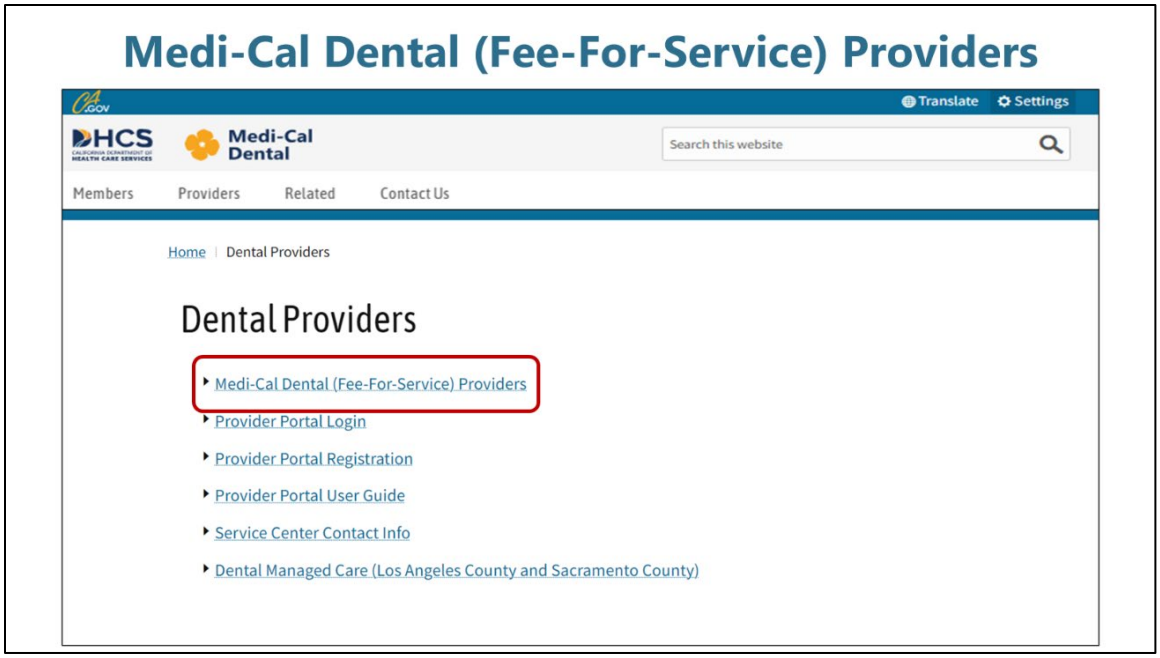
4.2 Medi-Cal Dental Provider Website

The Medi-Cal Dental Provider Handbook and Medi-Cal Dental Bulletins are available on the Medi-Cal Dental website at www.dental.dhcs.ca.gov.

The Provider Handbook has been developed to assist the provider and office staff with participation in Medi-Cal Dental. It contains detailed information regarding the submission, processing, and completion of all treatment forms and other related documents. The Provider Handbook should be used frequently as a reference guide to obtain the most current criteria, policies, and procedures of California Medi-Cal Dental.

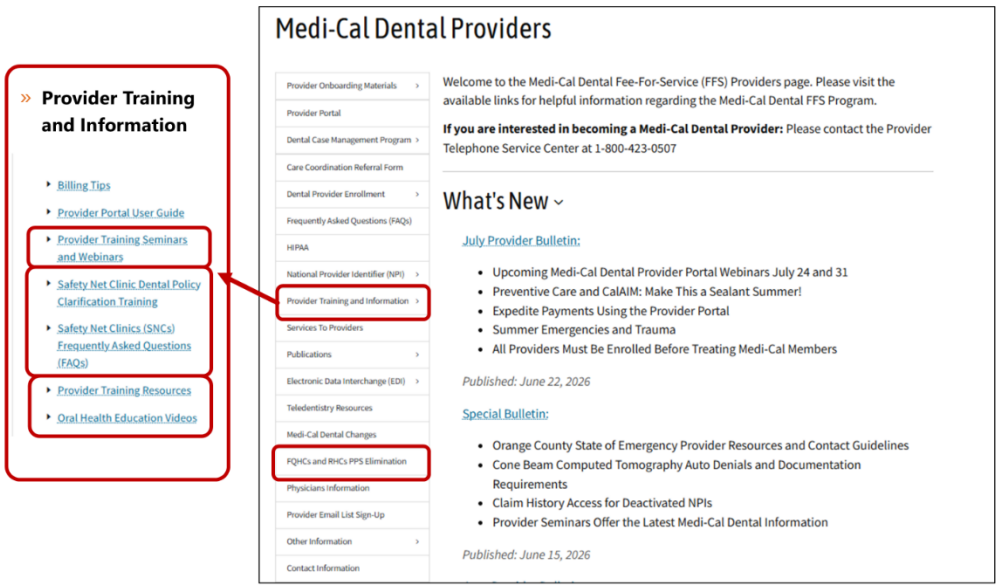
The Medi-Cal Dental Bulletins are published periodically to keep providers informed of the latest developments in Medi-Cal Dental. New bulletins will appear in the “What’s New Section” of the Medi-Cal Dental website and are incorporated into the “Provider Bulletins” section of the website. This section should be checked frequently to ensure that your office has the most updated information on Medi-Cal Dental.



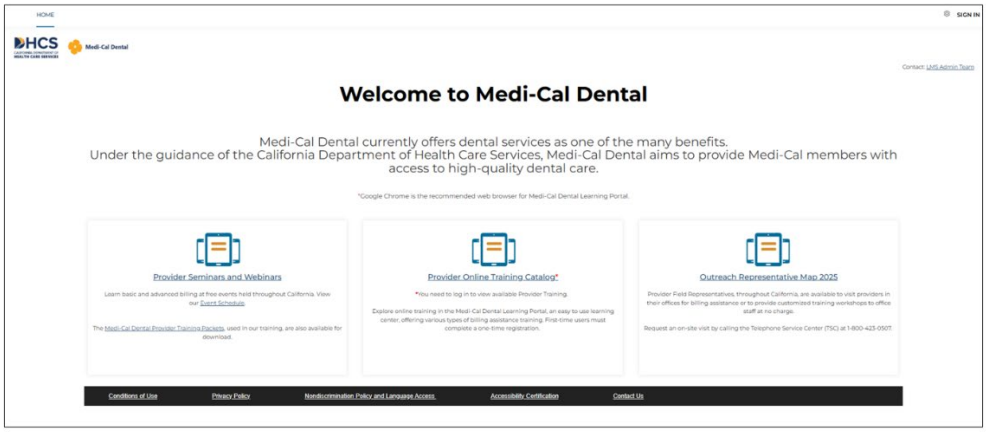

Medi-Cal Dental (Fee-For-Service) Providers
Translate
Settings
DHCS
Medi-Cal Dental
Search this website
Members
Providers
Related
Contact Us
Home | Dental Providers
Dental Providers
Medi-Cal Dental (Fee-For-Service) Providers
Provider Portal Login
Provider Portal Registration
Provider Portal User Guide
Service Center Contact Info
Dental Managed Care (Los Angeles County and Sacramento County)


Medi-Cal Dental Website
Dental Case Management
Dental Case Management Program Overview
Case Management Referral Form
Publications
Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA)
Provider Bulletins
Provider Handbook
Provider Forms
Provider Website Application User Guide
Statutes and Regulations
Medi-Cal Dental Providers
Welcome to the Medi-Cal Dental Fee-For-Service (FFS) Providers page. Please visit the available links for helpful information regarding the Medi-Cal Dental FFS Program.
If you are interested in becoming a Medi-Cal Dental Provider: Please contact the Provider Telephone Service Center at 1-800-423-0507
What's New
July Provider Bulletin:
Upcoming Medi-Cal Dental Provider Portal Webinars July 24 and 31
Preventive Care and CalAIM: Make This a Sealant Summer!
Expedite Payments Using the Provider Portal
Summer Emergencies and Trauma
All Providers Must Be Enrolled Before Treating Medi-Cal Members
Published: June 22, 2026
Special Bulletin:
Orange County State of Emergency Provider Resources and Contact Guidelines
Cone Beam Computed Tomography Auto Denials and Documentation Requirements
Claim History Access for Deactivated NPIs
Provider Seminars Offer the Latest Medi-Cal Dental Information
Published: June 15, 2026

Medi-Cal Dental Website



Learning Management System (LMS)



https://lms.dental.dhcs.ca.gov

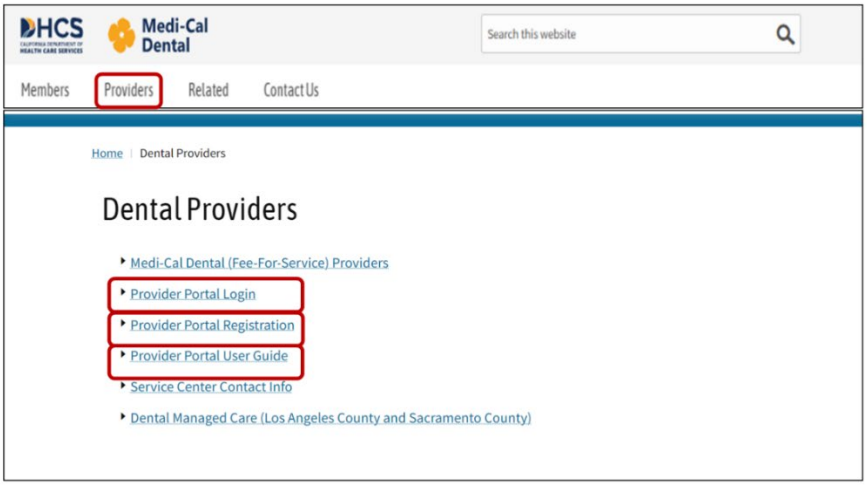
4.3 Medi-Cal Dental Provider Portal

The Medi-Cal Dental Provider Portal can be accessed from the Medi-Cal Dental website (www.dental.dhcs.ca.gov). The Provider portal will allow secure log-on for providers to access their:

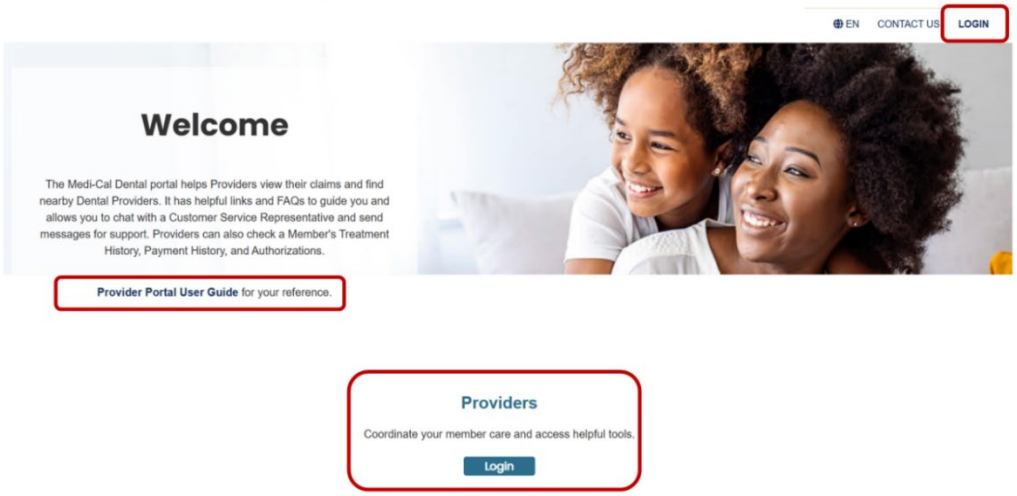
- Eligibility
- Treatment History
- Claims
- Seach Claim
- Seach Payment History
- Care Management
- Search Authorization
- Resources
- File Upload
- File Download
- Search Providers
- Maintenance
- Portal Profile Maintenance
- Managed Delegates
- Switch Providers
- Send secure messages
- Live Chat with Medi-Cal Dental TSC staff Monday through Friday, 8 a.m. to 5 p.m.
- Helpful links
- Broadcast messages

Providers can register themselves by clicking the “Provider Portal Registration” link available on the Medi-Cal Dental Provider Website page. It is recommended for the dentist or the owner of the practice set up the first account and then invite additional users, known as Delegates. Refer to the Provider Portal User Guide.

Provider Portal

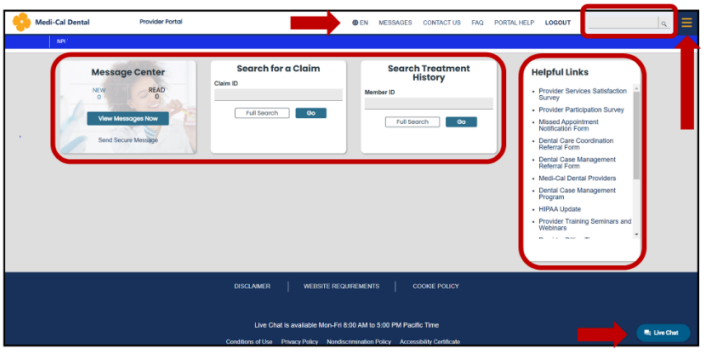


Login Provider Portal



Provider Portal Home Page

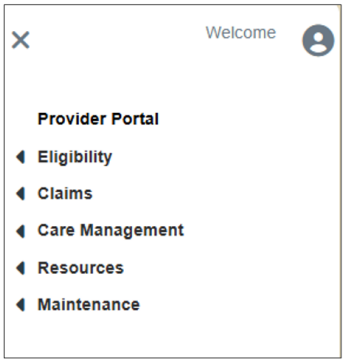
- At a Glance Bar
- Search
- Helpful Links
- Quick Link Tiles
- Live Chat
- Navigation Menu



The navigation menu ( ) allows users to easily access different areas of the provider portal by clicking on main menu topics to expand and reveal related sub-menu options. Key sections include Eligibility, Claims, Care Management, Resources, and Maintenance, each offering specific functions such as searching claims, reviewing payment history, checking treatment history, managing authorizations, and maintaining provider profiles or delegates. This structured layout helps users quickly find and then navigate to the information or task they need.

Navigation Menu

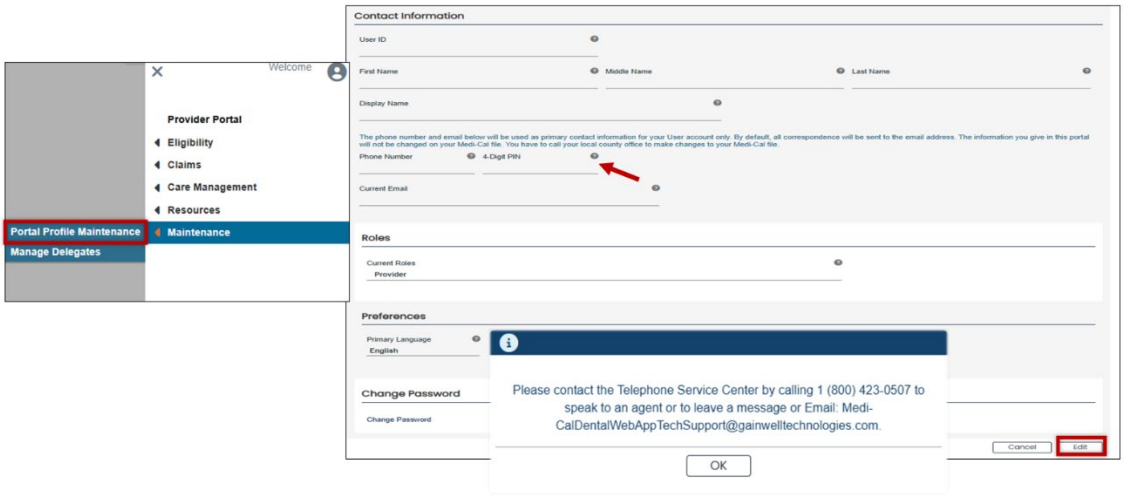
Click on menu topics to reveal sub menu topics



PORTAL MAINTENANCE

DHCS Medi-Cal Dental

Update Account Information



5 Member Term Descriptions

Child

- Member under the age of 21 (0-20)
- Scope of benefits based on aid code

Adult

- Member aged 21 and older
- Scope of benefits based on aid code
- For treatment that requires prior authorization, the Notice of Authorization (NOA) remains valid for members who reach their 21st birthday during the authorization period

Facility Resident

- Dental services for members who reside in a
  - SNF – Licensed Skilled Nursing Facility
  - ICF – Licensed Intermediate Care Facility
- Dental services do not have to be provided in the facility to be payable for Place of Service (POS) 4 or 5 residents

Pregnant Members

Members who are pregnant and up to 12 months of postpartum

- Pregnant members regardless of age, aid code, and/or scope of benefits are eligible to receive all procedures listed in the Manual of Criteria as long as all procedure requirements and criteria are met
- Prior authorization is waived for D4341/D4342 (Scaling and Root Planing)
- All radiographic requirements must be met except:
  - Bitewing requirements are waived for D4341/D4342
    - (Covered in Periodontics section of seminar)
  - Arch integrity radiographic requirements waived

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    - (Covered in Periodontics section of seminar)
  - Arch integrity radiographic requirements waived

6 California Advancing and Innovation Medi-Cal CalAIM

CalAIM: Overview

- CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal population by implementing a broad delivery system, program and payment reform.
- The major components of CalAIM were the successful outcomes of various pilots through the Dental Transformation Initiative (DTI).
- All FFS claims will be processed and paid in accordance with the Manual of Criteria (MOC) and the Schedule of Maximum Allowances (SMA).
- Effective January 1, 2022.

CalAIM: Three Oral Health Initiatives

- Preventive Services: Pay for Performance (P4P)
  - To increase statewide utilization of preventive services
- Caries Risk Assessment and Silver Diamine Fluoride Benefits
  - Caries Risk Assessment (CRA) bundle including the allowable increased frequencies for moderate and high-risk CRA bundles and Silver Diamine Fluoride (SDF) as new statewide dental benefits in alignment with national dental care standards
- Continuity of Care: Pay for Performance (P4P)
  - A flat rate performance payment to dental provider service office locations that maintain dental continuity of care by establishing a dental home for each patient and perform at least a yearly dental exam/evaluation for two or more years in a row

6.1 Resources and Forms for CalAIM

Department of Health Care Services CalAim Dental Initiative:
https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx

- Treating Young Kids Everyday (TYKE) training
  - https://www.cda.org/education-and-events/education/tyke-program/
- Attestation form
  - https://www.dhcs.ca.gov/provgovpart/denti-cal/Documents/DHCS-6213-CalAIM-Provider-CRA-Attestation-Form.pdf
- Caries Risk Assessment (CRA) form for Children
  - California Department of Health Care Services Caries Risk Assessment Form for Children Ages 0-6 Years of Age

» Questions about CalAIM:
  - dental@dhcs.ca.gov

Strengthening Many Lives Everyday (SMYLE) Training

Medi-Cal Dental has introduced *Strengthening Many Young Lives Everyday*, a **free** training now available through the Medi-Cal Dental Learning Management System (LMS).

SMYLE serves as an optional training that providers can complete to meet the one-time mandatory training requirement needed to receive reimbursement for the Caries Risk Assessment (CRA) bundle benefit. After completing the course, a certificate will be available for download and will also be emailed to the address linked to your account.

Important: once the TYKE Training is completed a Certificate of Completion will be issued. It is required to submit this to Medi-Cal with the attestation form whether you take the training through CDA or LMS.

7 Medi-Cal Dental Criteria

Criteria Covered Today

- Emergency Services
- Diagnostic Services
- Preventive Procedures
- Restorative Procedures
- Crowns
- Prefabricated Crowns
- Endodontics
- Periodontics
- Registered Dental Hygienist in Alternative Practice (RDHAP)
- Removable Prosthodontics
- Extractions
- Anesthesia
- EPSDT – Early Periodic Screening, Diagnostic, and Treatment

Medi-Cal Dental Criteria

- The Manual of Criteria (MOC) is put forth by the Department of Health Care Services (DHCS) and establishes the criteria for the procedures
  - The criteria apply to all providers and members
  - Medi-Cal Dental does make some modifications to the submission requirements

See the Provider Handbook Section 5 (Manual of Criteria) for more information

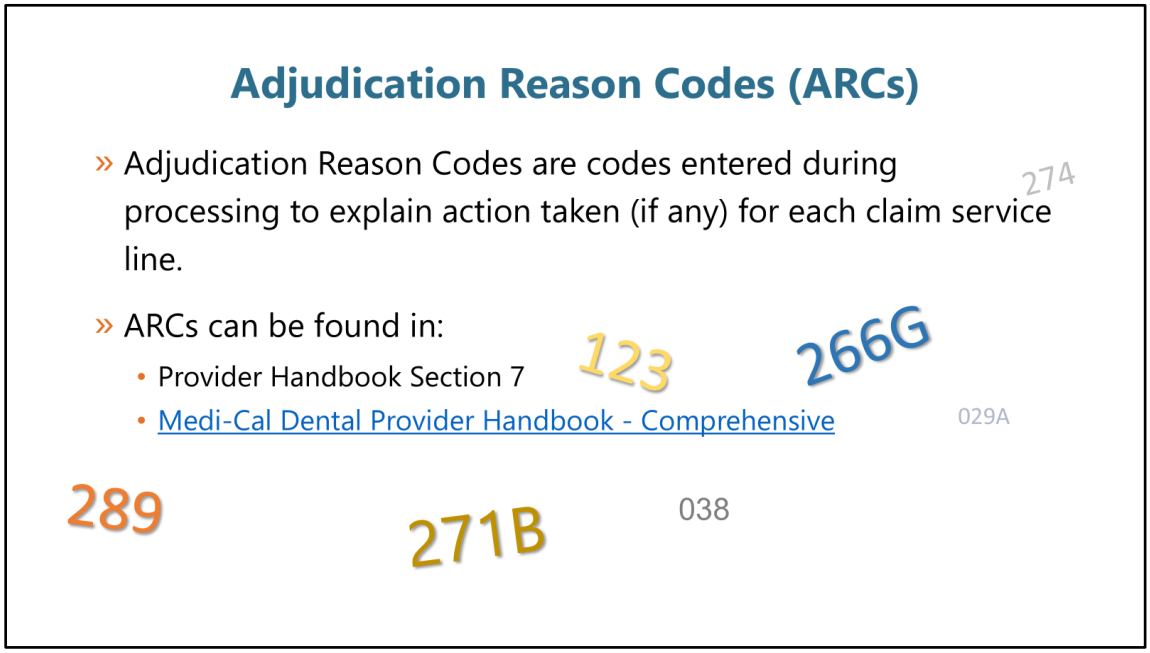
8 Adjudication Reason Codes

In adjudicating claim and TAR forms, it is sometimes necessary to clarify the criteria for dental services under Medi-Cal Dental. These processing policies are intended to supplement the criteria. The Adjudication Reason Code is entered during processing to explain unusual action taken (if any) for each claim service line. These codes will be found on Explanations of Benefits (EOBs) and Notices of Authorization (NOAs).

ARCs can be found in:

- Provider Handbook Section 7

  Medi-Cal Dental Provider Handbook - Comprehensive



Multiple Authorizations

- Currently authorized procedures can be seen in the Provider Portal
- Most procedures that require prior authorization can be authorized to multiple providers
- However, if there is **removable prosthodontic** treatment authorized to a different billing provider and your patient wishes to authorize to your office instead
  - Include a letter from the patient with your TAR submission indicating they want to cancel previous authorization and authorize to your office instead
  - Ensure the letter is signed by the Medi-Cal member
  - This is how to avoid Adjudication Reason Code 300A
    - *ARC 300A: "Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office."*

9 Emergency Services

Emergency Services for Limited Scope Aid Codes

» Some members have Emergency Services Only Aid Codes
  • These cover specific emergency procedures, regardless of age

» If a member has one of these aid codes, the only procedures allowed are those listed in the Provider Handbook Section 4

See the Provider Handbook Section 4 (Treating Members) for more information.

Emergency Dental Codes

» The following Current Dental Terminology (CDT) Codes are identified emergency dental procedures:

» D0220, D0230, D0250, D0330, D0502, D0999, D2920, D2940, D2941, D3220, D3221, D6092, D6093, D6930, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7490, D7510, D7511, D7520, D7521, 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, D7979, D7980, D7983, D7990, D9110, D9210, D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, D9247, D9248, D9410, D9420, D9430, D9440, D9610, D9910, D9920, D9930, D9951

Medi-Cal Dental Benefit Changes

» Effective **July 1, 2027**: Medi-Cal Dental will no longer cover non-emergency dental services for some members due to their immigration status

» This change applies to members 19 and older who are not eligible for federally funded full-scope Medi-Cal

» Exceptions to these benefit changes include:
  • Children under 19 (regardless of immigration status)
  • Designated by the county as pregnant or up to one year after pregnancy ends
  • Designated by the county as foster youth or former foster youth under 26 who were in foster care on their 18th birthday

Member Plan Transitions

- Members 19 and older who are losing non-emergency dental coverage and who are enrolled in a Dental Managed Care Plan (Dental MCP) will be transitioned to Medi-Cal Dental Fee-For-Service (Dental FFS)
- Members 19 and older who are designated by the county as pregnant/postpartum, and foster youth/former foster youth under 26, will also receive their full-scope dental services through Medi-Cal Dental FFS
- Members who are under 19 will remain in their Dental MCP and will continue to receive full-scope dental services

Emergency Dental Services and Eligibility Verification

- Members affected by the benefit changes will still have access to emergency dental services via Medi-Cal Dental FFS
- Covered emergency dental services are those treatments needed right away to stop severe pain or to diagnose and treat sudden serious medical problems
- Providers must use one of the following methods to verify member eligibility prior to treatment:
  - Automated Eligibility Verification System (AEVS)
  - Medi-Cal Website (Provider Portal)
- Please reference Medi-Cal Dental Benefit Changes for more information about these benefit changes at www.dhcs.ca.gov

Emergency Documentation

- Emergency Certification Statement signed by the treating dentist is required for members with aid codes for emergency services only
  - Paper claims – use Comments Box 34
  - EDI Claims – signature requirement waived though documentation must still be present

D9110

Palliative Emergency Treatment of Dental Pain

- "Hands-On" emergency visit
- Payable once per date of service
  - Not per procedure or per tooth
- Requires documentation
- D0171 can only be billed as D9110 or D9430 and is not payable separately

Documentation

- For emergency procedures and members with Emergency Only Aid Codes, documentation shall include:
  1. Chief Complaint
  2. Diagnosis with tooth number or area
  3. The treatment performed

D9995 Teledentistry

Teledentistry – Synchronous; Real-time encounter

- Written documentation for payment shall include the number of minutes that the transmission occurred
- Payable once per date of service per patient, per provider up to a maximum of 90 minutes at $.24/minute
- Bill number of minutes in the Quantity field on your claim

D9430 - Criteria

Office Visit for Observation – No Other Services Performed

- A benefit once per member, per date of service, per billing provider
- Not a benefit when rendered in a facility (SNF/ICF)
  - Use D9410 in facility

D9430

- "Hands-Off" visit
- Observation visit only that may include prescribing, reappointing, referral to specialist, etc.
- No documentation required for payment purposes, but documentation must be in member record according to Medi-Cal Dental guidelines
- Although the ADA description of the code indicates "No other services performed," D9430 can be billed, for example, when a member schedules an emergency appointment, and the determination is made that additional same-day treatment is required. The D9430, in this context, reimburses for the examination time taken to determine what treatment is necessary.

D9430

- D9430 should be billed for urgent or emergent appointments where your patient has a new concern
- It should not be billed for routine follow-ups, denture adjustments, denture progress visits, buildups, crown preparation appointments, suture removal, etc., nor as a routine "appointment fee"
- It should generally not be billed in the context of a normally scheduled appointment, nor used as a substitute code to request reimbursement when the procedure documented in the patient record is not payable

Teledentistry and D9430

- D9430 can be used for live streaming video or telephone with a Medi-Cal member with oral health issues in lieu of an in-person office visit when billed with D9995

Teledentistry and D9430

- D9430 as part of teledentistry is only allowable for a conversation between the Medi-Cal member and the Medi-Cal provider about oral health issues as their chief complaint
- CDT code D9430 should not be billed for conversations with office staff about scheduling or rescheduling appointments

See Provider Bulletin March 2026 Volume 06, Number 8 for more information
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_42_Number_06.pdf

Recementation

- D2910 Inlay
- D2920 Crown
- D6930 FPD

- Benefit once in 12 Months without radiographs or documentation
- Additional Requests within 12 months require documentation

D2940

Placement of Interim Direct Restoration

- For use as a temporary restoration
  - Requires tooth number
  - Benefit once per tooth per lifetime
  - Requires pre-op radiograph for payment
  - Not a benefit for RCT-treated tooth (use D9110)
  - Not a benefit on the same day as a definitive restoration in the same tooth

D3221

Pulpal Debridement

- Benefit for initial Open & Drain – for the relief of acute pain prior to conventional root canal therapy
- No prior authorization
- No documentation or radiograph required for payment
- For permanent teeth or over-retained primary teeth with no successor
- A benefit once per tooth
- Not for root canal therapy visits once RCT has been authorized
- For additional emergency visits use D9110

D7510

Incision and Drainage of Abscess, Intraoral Soft Tissue

- Requires written documentation of condition, specific tooth or area, rationale for treatment and any pertinent history
- Benefit once per quadrant per date of service
- Not a benefit with other treatment in the same quadrant on the same date of service except for radiographs
- Fee includes the incision and placement and removal of any surgical draining device

D9910

Application of Desensitizing Medicament

- Requires Documentation
  - Tooth or teeth treated
  - Specific treatment provided
- A benefit once per date of service
- Permanent teeth only
- Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose the emergency condition
- This procedure is considered an emergency treatment only

D9440

Office Visit After Regularly Scheduled Hours

- Documentation required
  - Use the formula for emergency visits
  - Time and day of week required (ARC 267i)
- A benefit to compensate the provider for travel time outside of normal office hours
- A benefit once per member per date of service per provider

9.1 Diagnostic Services

D0145

Oral Evaluation for a Member Under Age 3 and Counseling with Primary Caregiver

- A benefit under the age of 3
  - D0150 or D0120 not a benefit under age 3
- A benefit once every three months per billing provider
- This is the only billable examination code for members under age 3

D0150

Comprehensive Oral Evaluation

- A benefit once per member per billing provider for initial evaluation for members age 3 and older
- Additional D0150 allowable if no D0120 or D0150 paid to same billing provider within previous 36 months

D0120

Periodic Oral Evaluation

- A benefit once every 6 months per billing provider for members age 3 through 20
  - At least 6 months after D0150 by same billing provider
- A benefit once every 12 months per billing provider for members age 21 and older
  - At least 12 months after D0150 by same billing provider

D0120

Periodic Oral Evaluation

- Ensure D0150 has been billed and paid for your patient before billing D0120 even if D0145 has been paid previously
- A benefit once every 6 months per billing provider for members age 3 through 20
  - At least 6 months after D0150 by same billing provider
- A benefit once every 12 months per billing provider for members age 21 and older
  - At least 12 months after D0150 by same billing provider

D0210

Radiographs – Complete Series (Including Bitewings)

- Not a benefit under age 11
  - Bill individual radiographs
- Complete series shall be at least one of the following combinations
  - 10 periapicals and bitewings
  - 8 periapicals, 2 occlusals, and bitewings
  - Pano, bitewings, and a minimum of 2 periapicals

D0210

- A benefit once in a 36-month period per billing provider
- Not payable when bitewings have been paid within 6 months to the same provider

D0220 D0230

Periapical 1st Film, Periapical Each Additional Film

» Submission of radiographs not required for payment

» Benefit to a maximum of 20 periapicals in a 12-month period

» Periapicals taken as part of FMX are not considered against this 20-radiograph limit

D0272 D0274

Bitewings

- 2 Films D0272
- 4 Films D0274

» A benefit once every 6 months per billing provider

» Not a benefit within 6 months of complete series D0210

» D0274 not a benefit under age 10

D0330

Panoramic Film

» A benefit once in a 36-month period per member per billing provider

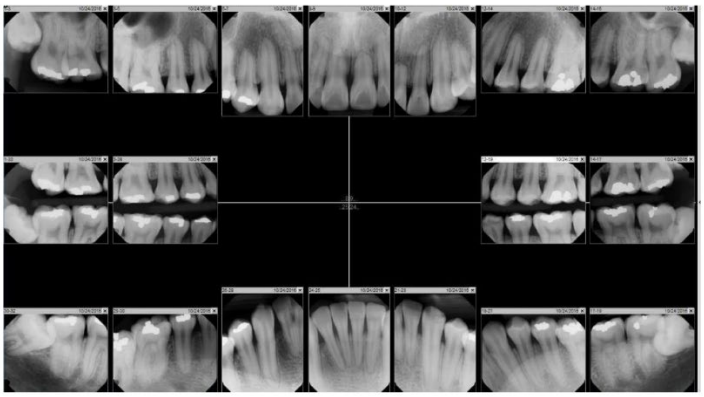
Radiograph and Photograph Currency

- What is a current photo or radiograph?
  - Primary tooth – 8 months
  - Permanent tooth – 14 months
  - Arch integrity – 36 months
- Submitted photos or radiographs must reflect the current state of the tooth or area
  - If procedures have been performed since the date of the photo or radiograph, the imagery might not be current even if taken within the above timeframe

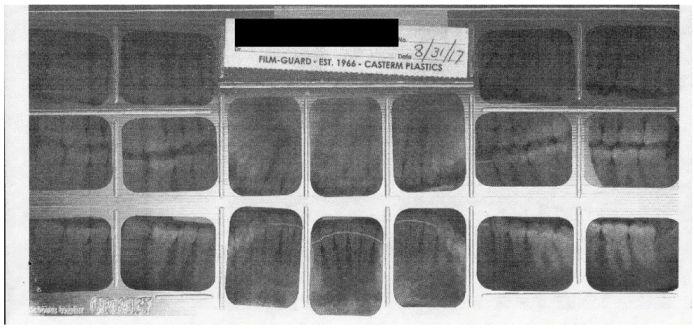
Radiograph and Photograph Submission

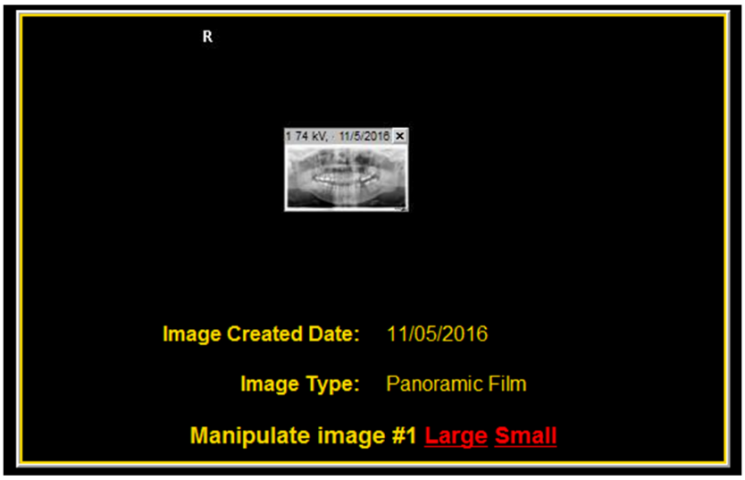
- Must be dated and current
- Must include member name
- Must include orientation – indicate tooth number, Left/Right, or quadrant/area as needed
- Must be of diagnostic quality

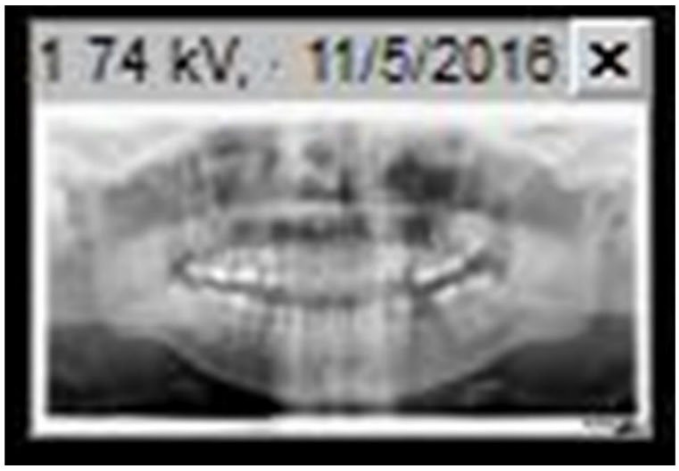
- Duplication and radiographic technique must be of diagnostic quality



9.1.1 Not Diagnostic Quality







D0350 - Photographs

- Photographs must be appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs in order to be payable
- Not a benefit when used for member identification
- Recommended to supplement radiographs when the radiographs do not demonstrate medical necessity

D0350 - Photographs

- Submit photos with the procedure they support
- Maximum of 4 photos payable per date of service
- Additional photos may be submitted to demonstrate medical necessity

D0350 - Photographs

- By a wide margin, the most common denial for photos is due to **lack of clear orientation**
- When clear orientation is not provided, D0350 cannot be paid **and** the photos cannot be used to aid in adjudication
- Even if not submitted for payment, a photo submitted to aid in adjudication cannot be used by the adjudicator if orientation is not clearly provided

Photo Orientation

- Photos submitted in this fashion are denied 266G and cannot be used for adjudication

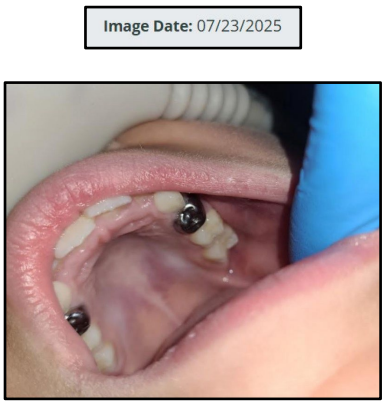
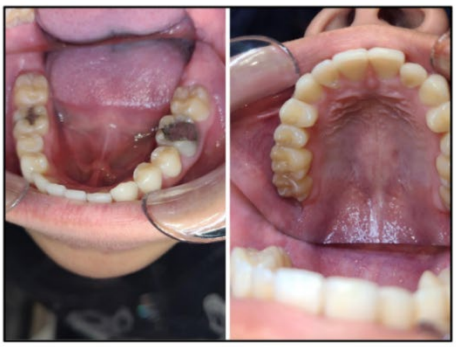


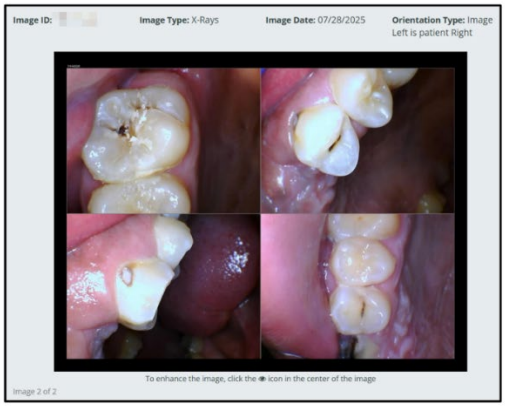
Photo Orientation



- Photos submitted in this fashion are denied 266G and cannot be used for adjudication

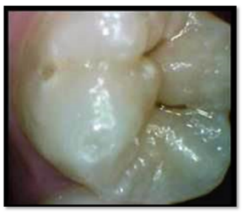
Photo Orientation

- Clearinghouses may include "Image Left is Patient Right" but this does not usually work well for photos
- Recommend including orientation within the image itself



- Date on submitted photo must match the date of service on the claim form for the photo being billed
- Date of Service for photo does not need to be the date of service of the restoration

04-15-24 Name #14



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
		1 Oral/Facial Photographic Images	4-15-24	1	D0350
14	OL	2 Resin Base Composite - two	4-30-24	1	D2392
		3 surfaces, posterior			
		4			
		5			
		6			
		7			

Photos on TARs

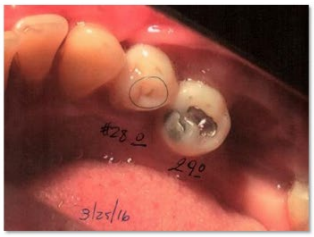
- A TAR is any document where at least one Claim Service Line has no Date of Service entered
- We cannot prior authorize photos (ARC 031A)
- How does a provider get paid for a photo that supports a TAR?

Photos on TARs

- Any photo must be submitted with a Date of Service to be payable
- Because this crown does not have a Date of Service, this document is a TAR
- Submit NOA for payment of the photo even if crown is not authorized
- If the crown is authorized, do not submit NOA until all treatment on the NOA is complete

EXAMINATION AND TREATMENT

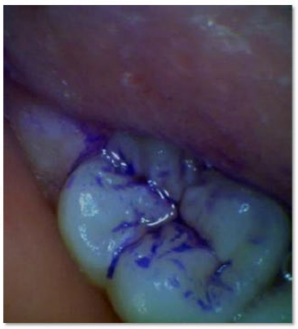
26. TOOTH # LTR. ARCH. QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER
		1 Oral/Facial Photographic Images	4-15-26	1	D0350
14		2 Crown – porcelain fused to		1	D2751
		3 predominantly base metal			
		4			
		5			
		6			
		7			



ARC 029F - member name does not match or is not on the X-ray mount, envelope or photograph

Since images are scanned for the dental consultants, put all labeling information on the front

Caries dye renders photos nondiagnostic



This photo was denied with ARC 266C - Radiographs or photographs are non-diagnostic for the requested procedure.

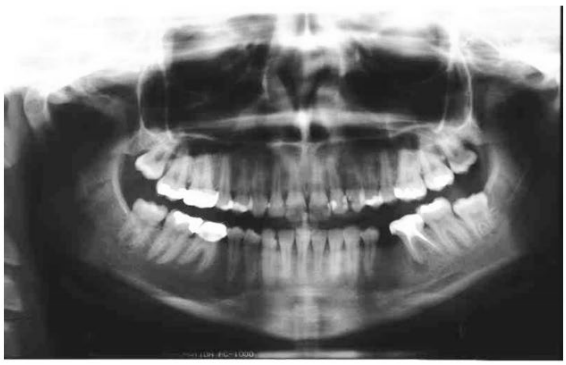
Radiograph/Photograph Tips

- Medi-Cal Dental no longer returns radiographs or photos
- Submit only duplicates – never send your last film to us
- Dental consultants no longer handle physical radiographs, only scans, so duplication must be of high quality to be diagnostic
- Ensure high quality output if printing images

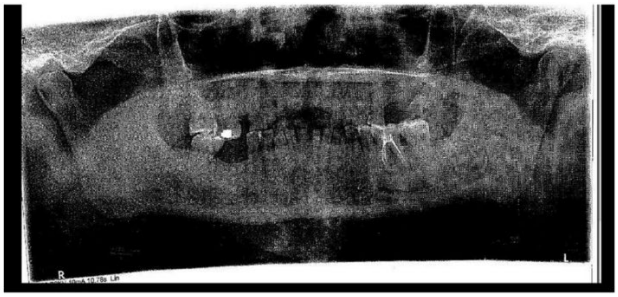
Arch Integrity

- Arch integrity and overall condition of the mouth, including the member's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5-year prognosis for the teeth or abutments
- Anterior periapical radiographs and bite-wings are enough to establish arch integrity of the arches
- Arch integrity radiographs are not the same as an FMX
- If arch integrity radiographs are not submitted the treatment will be denied

Arch Integrity

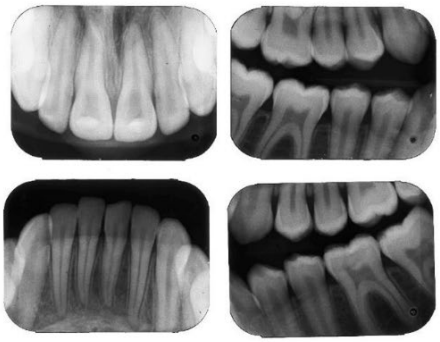


Arch Integrity



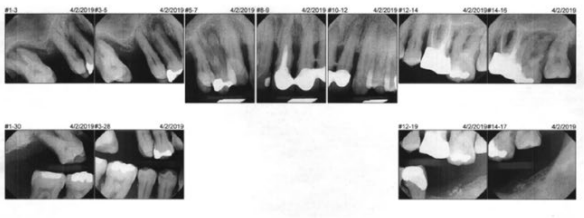
» 266H – Radiographs submitted to establish arch integrity are non-diagnostic

Arch Integrity



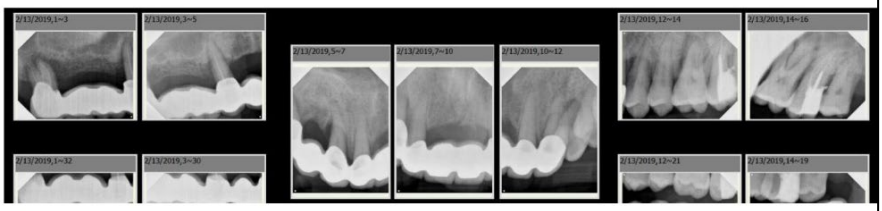
» Arch integrity is established in this case without an entire FMX

Arch Integrity



» 271C – Arch lacks integrity

Arch Integrity



» 271C – Arch lacks integrity

9.2 Preventative Procedures

Child – Under Age 6

- Prophylaxis D1120 a benefit once in a six-month period per member without prior authorization
- Fluoride D1206 or D1208 a benefit once in a four-month period

Child – Age 6 Through 20

- Prophylaxis D1120 and Fluoride D1206 or D1208 a benefit once in a six-month period

Adult

- Prophylaxis D1110
- Fluoride D1206 or D1208
- A benefit once in a 12-month period per member without prior authorization

- Note that Prophylaxis and Scaling & Root Planing procedure frequencies are ***per member***, not per billing provider
  - Provider should verify prior to rending services using the Provider Portal or the Provider Telephone Service Center

SNF - ICF

- Prophylaxis (D1110 or D1120) and fluoride (D1206 or D1208) are a benefit once in a four-month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility
  - The member can have the cleaning/fluoride rendered in the dental office or at the facility
  - The Place of Service 04 or 05 should be entered on the TAR/Claim form based on where the patient lives, not necessarily where the treatment is rendered

D1351 - Sealant

- Benefit under age 21 for 1st and 2nd permanent molars
- No prior authorization, radiographs, or documentation
- On claim form, indicate tooth number and surface(s) being sealed
- Occlusal surface must be sealed, must be caries free, and must be restoration free
- Original provider responsible for replacement for 36 months

D1354

Caries Arresting Medicament – Per Tooth

- Requires a tooth code
- A benefit for all ages
  - For members under age 7
    - Photograph required
    - Flexibilities allowed for members under age 4 (per W&I code 4512)
- For members age 7 or older, in addition to a current intraoral photograph, submit a current, diagnostic radiograph and document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal
- D1354 is a benefit once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth

D1320

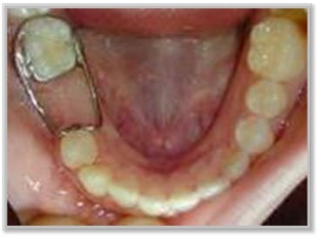
Tobacco Counseling for the Control and Prevention of Oral Disease

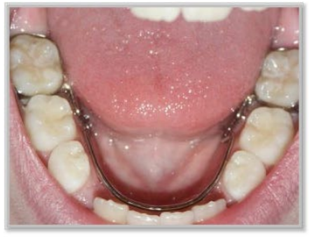
- Submission of dental record documentation is not required for payment
- A benefit only in conjunction with at least one of the following procedures: Comprehensive oral evaluation (D0150), Periodic oral evaluation (D0120); Prophylaxis (D1110 or D1120); Scaling and root planning (D4341 or D4342); or periodontal maintenance (D4910)
- A benefit to encourage tobacco cessation; not to be billed for those who are not tobacco/vape users

D1320

- Documentation in the provider record of a face-to-face encounter shall include:
  - The five A's of tobacco dependence – Ask, Advise, Assess, Assist, Arrange. If unwilling to quit document the patient's expressed roadblocks
- Provider bulletin – May 2019 (Vol 35, Number 15)
  - https://dental.dhcs.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_15.pdf

Space Maintainers





Space Maintainers

- Prior authorization not required
- Require pre-operative radiograph(s)
- Unilateral space maintainers require a quadrant code
  - Our system will assign an arch code for bilateral space maintainers based on the procedure code
- Indicate the missing primary molar(s)
- Not a benefit for anterior teeth

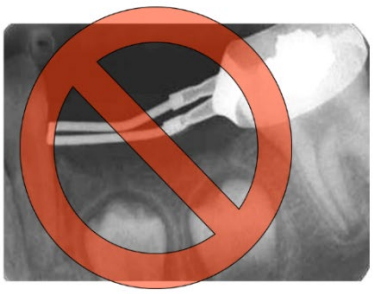
Unilateral Space Maintainers

- Fixed, D1510
- Distal Shoe Space Maintainer – Fixed, D1575
- Quadrant code required for unilateral space maintainers
- Indicate missing primary molar
- Pre-op radiograph required

Unilateral removable space maintainer D1520 is not a benefit

Unilateral Space Maintainers

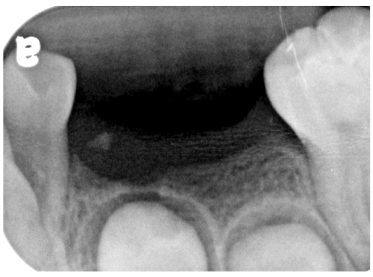
- A fixed unilateral space maintainer is only a benefit to maintain the space of a single primary molar
- ARC 197A
- Bilateral space maintainer indicated



A unilateral space maintainer for more than one molar space is not a benefit of Medi-Cal Dental

Bilateral Space Maintainers

- Fixed, D1516 Maxilla
- Fixed, D1517 Mandible
- Removable, D1526 Maxilla
- Removable, D1527 Mandible
- Arch code is system-assigned based on procedure code
- Indicate missing primary molars

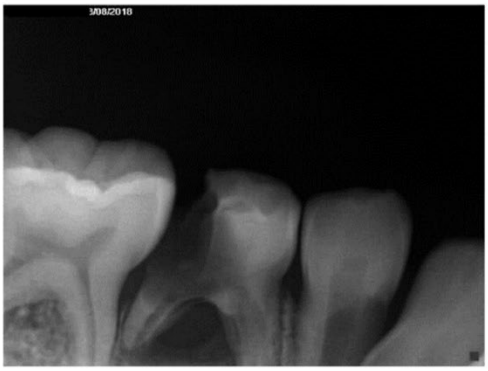


Bilateral Space Maintainers

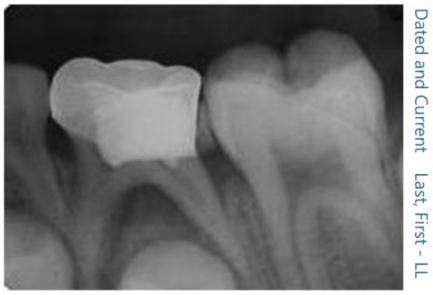
- Pre-op radiograph or radiographs required
  - More than one radiograph if molars missing on opposite sides
- Bilateral space maintainers shall be attached to teeth on both sides of the arch
- All clasps, rests, and adjustments included in fee

Space Maintainer Radiographs

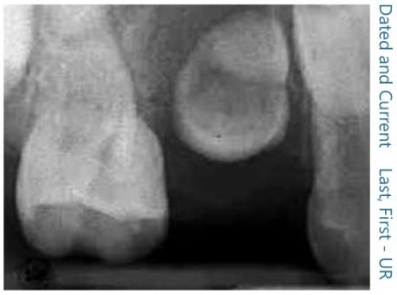
- Should depict adequate space and that the premolar is not near eruption



Space Maintainer Radiographs



- Before the extraction is acceptable

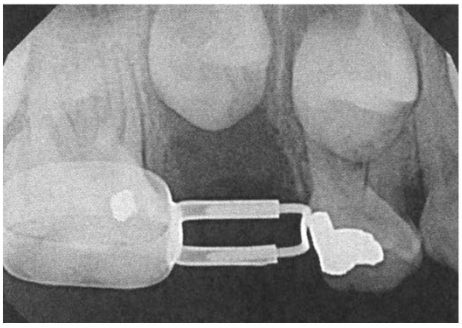


- After extraction but before placement of space maintainer is also acceptable

Space Maintainer Radiographs

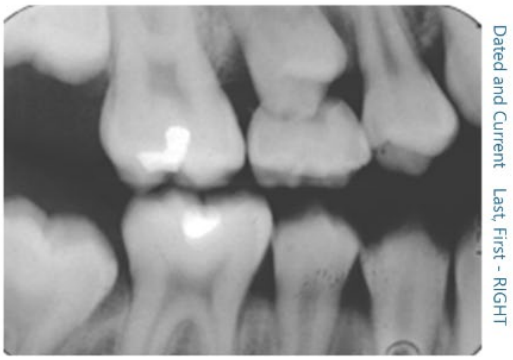
029E

» Payment denied due to date of radiograph/photograph is after the date of service or appears to be post-operative



Adjudication Reason Code 192

» Permanent tooth near eruption



Space Maintainer Replacement

- Space maintainers are a benefit once per lifetime
- Replacement requires documentation and current radiograph

Space Maintainer Recementation

- D1551, D1552, D1553
- Requires quadrant or arch code as appropriate
- A benefit once per billing provider without documentation
- Additional recementation procedures require documentation
- A benefit under age 18

Space Maintainer Removal

- D1556, D1557, D1558
- Requires quadrant or arch code as appropriate
- No documentation or radiographs required
- Not a benefit to original billing provider – removal included in fee for placement

9.3 Restorative Procedures

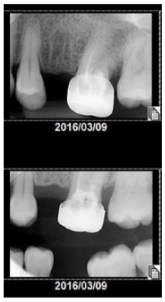
Restorative Procedures

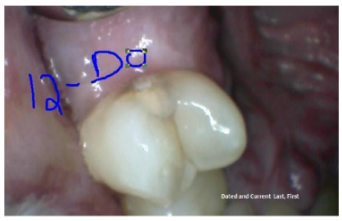
For amalgams, composites and prefabricated crowns:

- Prior authorization not required – submit restorations and prefabricated crowns on a claim
- Submission of pre-operative radiographs not required for payment, with the following exception
  - Replacement restoration by the same provider
    - Primary teeth within the first 12 months
    - Permanent teeth within the first 36 months
    - Payable when replacement is beyond the control of the provider
      - Loss of restoration, fracture, recurrent caries
    - A replacement restoration is: same tooth, same surfaces

Use of Photos

- When radiographs fail to demonstrate need, submit photographs as additional documentation





#12 DO

Restorative Procedures

- When radiographs are required, unacceptable documentation for lack of radiographs includes:
  - Patient/parent refused radiographs
  - Cannot take radiographs because provider does not have access to portable radiograph unit
- In cases not requiring general anesthesia or procedural sedation, photographs may be substituted for radiographs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or Claim.

Restorative Procedures

» Remember that even though Medi-Cal Dental may not require submission of radiographs for payment, adequate documentation of the medical necessity for all rendered procedures must be part of the patient record. This documentation may be in the form of radiographs, photographs, etc.

W&I Code Section 4512

» For members under age four and for members with a developmental disability of any age, the medical necessity for all restorations and prefabricated crowns can be established with a single radiograph or photograph demonstrating caries

- For developmentally disabled members, document the member's diagnosis or document that they are a Department of Developmental Services Consumer/Regional Center client

Amalgams and Composites

» Surfaces listed on the same CSL are considered connected

» Non-connected restorations on the same tooth for the same date of service shall be submitted on separate CSLs

» Example: Tooth #8

- MI D2331 + DI D2331 performed on same Date of Service
- Will be paid as MID – D2332

Amalgams and Composites

- Separate restorations on the same tooth are allowable when different materials are used
- Example: Tooth #3
  - MOD Amalgam D2160
  - B Composite D2391
  - Both restorations payable

Amalgams and Composites

- Two separate single surfaces payable on a tooth when surfaces are non-adjacent
- Example: #8
  - D2330 M Composite
  - D2330 D Composite
  - Both are payable

Restorative Procedures

- If bitewings are submitted and the destruction appears to encroach upon the pulp, submit a PA radiograph fully depicting the apex/apices
- When restorative procedures are reviewed, PA radiographs are required for endodontically treated permanent teeth

9.4 Crowns

Laboratory-Processed Crowns

- Requires prior authorization
- Tooth #
- PA Radiograph of entire tooth
- Post-Endo film (if applicable)
- Radiographs to demonstrate arch integrity if age 21 or older
  - Waived if RCT completed within past six months

Laboratory-Processed Crown Codes

- Resin (Indirect) – D2710, D2712, D2721
- Porcelain – D2740
- Porcelain fused/predominantly base metal – D2751
- ¾ Crowns D2781, D2783
- Cast base metal – D2791

Lab Crown Policies

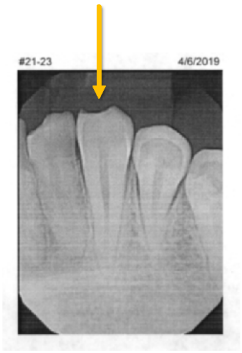
- A benefit once in a 5-year period
- Not a benefit for
  - Members under age 13
  - 3rd molars unless the tooth first meets the criteria and is occupying the 1st or 2nd molar position
- Noble metals are not a benefit
- Payment is made upon final cementation; there is no partial payment provision for crowns
- A benefit for endodontically treated premolars and molars, and can be authorized on the same TAR as root canal

Lab Crowns - Anterior

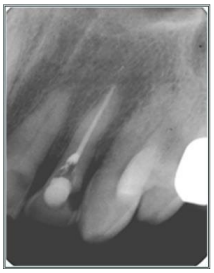
- Involvement of four or more surfaces including an incisal angle, or
- Destruction of more than 50% of the anatomical crown
- History of endodontic therapy not an automatic qualifier for crown in the anterior region

Lab Crowns - Anterior

- #22 Denied with ARC 113



- #10 Allowed even without incisal edge involvement due to greater than 50% destruction of anatomical crown



Lab Crowns - Premolar

- 3 surfaces including 1 cusp involved when there is no history of endodontic therapy
  - "Involved" can mean missing, undermined by caries, consisting solely of unsupported enamel, etc.
  - If a radiograph does not clearly demonstrate, photographs and/or narrative documentation should be provided.

Lab Crowns - Molar

- 4 surfaces including 2 cusps involved when there is no history of endodontic therapy
  - "Involved" can mean missing, undermined by caries, consisting solely of unsupported enamel, etc.
  - If a radiograph does not clearly demonstrate, photographs and/or narrative documentation should be provided.

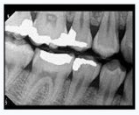
Recommendations for Crowns TARs

- References to large existing fillings not required
- Photos recommended when radiographs do not clearly demonstrate all surfaces/cusps involved
- Posterior Teeth: References to percentage of tooth structure missing should be replaced with references to exactly which surfaces and cusps are involved
- Recommend use of dental terminology rather than layman's terms to distinguish between craze lines and fractures involving dentin

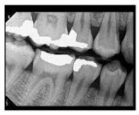
ARC 113, 113A

- ARC 113 – tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment
- ARC 113A – Per history, radiographs, or photographs it has been determined that this tooth has been recently restored with a restoration or prefabricated crown

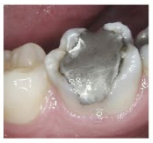
Photos and Crowns



ARC 113
#30



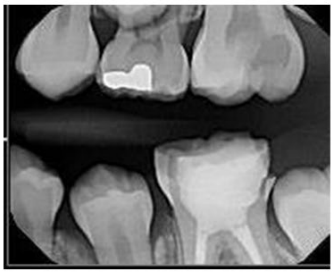
PA required – BW used to illustrate only



Crown
Allowed
#30

ARC 113B

- Per radiographs, the tooth/eruption pattern is developmentally immature.
- Please re-evaluate for alternate treatment



ARC 268

- When a crown does not demonstrate open margin or recurrent decay on a radiograph, it can be denied with ARC 268
- A photo can be used to supplement the radiographs in this case
- You can also consider submitting narrative documentation
- When we apply ARC 268 it is not to question a provider's professional judgement; usually it indicates that with the documentation that has been submitted, the medical necessity for the procedure has not been established.

D2952 – D2954

- Cast or prefabricated post & core do not require prior authorization
- Requires tooth number, PA radiograph, and arch integrity radiographs (age 21 and older)
- Tooth must be endodontically treated
- A benefit only in conjunction with allowable prefabricated or lab crowns – the crown must have been paid or authorized by Medi-Cal Dental

9.5 Prefabricated Crowns

Prefabricated Crowns

- Stainless Steel (Primary tooth) – D2930
- Stainless Steel (Permanent tooth) – D2931
- Resin (Primary or Permanent tooth) – D2932
- Stainless Steel with Resin Window (Primary or Permanent tooth) – D2933

Prefabricated Crowns – Primary Teeth

- Prior authorization is not required
- Tooth # required
- A benefit once in a 12-month period

Prefabricated Crowns – Primary Teeth

- To qualify for a prefabricated crown, a primary tooth must demonstrate:
  - Three or more tooth surfaces involved or
  - Extensive two-surface interproximal restoration or
  - In conjunction with pulpotomy

Prefabricated Crowns – Permanent Teeth

- D2931, D2932, D2933
- Prior authorization not required
- Tooth # required
- A benefit once in a 36-month period

9.6 Endodontics

D3220

Therapeutic pulpotomy, primary tooth

- No prior authorization, documentation, or radiograph required
- A benefit once per tooth

D3230 D3240

Pulpectomy, primary tooth

- No prior authorization, documentation, or radiograph required
- A benefit once per tooth

D3310 D3320 D3330

Initial root canal therapy

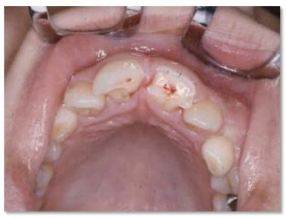
- Prior authorization not required for children
  - Can be submitted on claim – no radiographs required for payment
- Prior authorization is required for adults
- Requires a periapical depicting entire tooth
  - Also requires arch integrity radiographs for adults
- Tooth will be evaluated for longevity, periodontal status, and restorability

D3310 D3320 D3330

- Not a benefit for 3rd molars unless occupying the 1st or 2nd molar position
- Date of service on NOA is final treatment date
- Post-treatment radiograph not required for payment
  - Documentation and appropriate radiographs must still be maintained in the treatment record in accordance with Standards of Care
- Fee includes
  - All treatment and post-treatment radiographs
  - Temporary restoration

D3310 D3320 D3330

- Prior authorization may be waived when one of the following has occurred
  - Tooth has been accidentally avulsed
  - Crown fracture has exposed vital pulp tissue



D3346 D3347 D3348

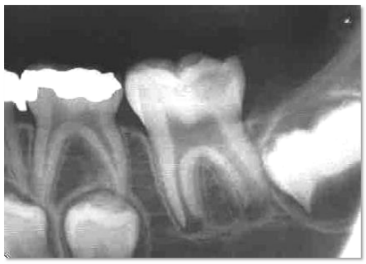
Root canal re-treatment

- Prior authorization not required
- Not a benefit to original provider within 12 months of initial treatment

D3222

Partial Pulpotomy for Apexogenesis

- For vital permanent teeth with incomplete root development
- A benefit once per tooth
- Under age 21
- Requires
  - Prior authorization
  - PA radiograph



D3351

Apexification

- A benefit for permanent teeth under age 21
- Initial visit – D3351
- Requires
  - Prior authorization
  - PA radiograph
- After D3351 completed member is eligible for D3352 once on a claim

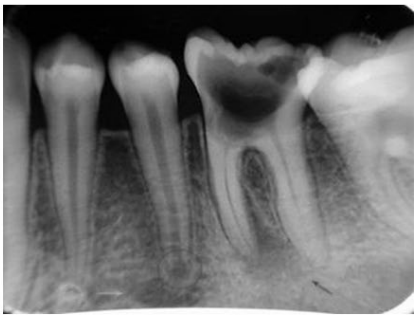
D3921

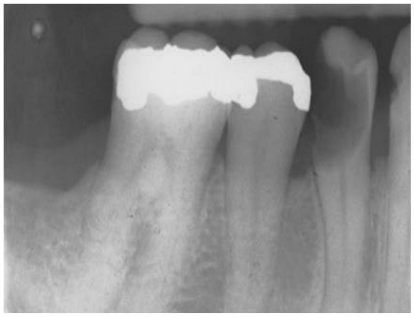
Decoronation or Submergence of an Erupted Tooth

- Prior authorization is required
- Tooth code is required
- Periapical radiograph is required
- Narrative documentation is required – describe the specific conditions addressed by the procedure and rationale demonstrating medical necessity

ARC 271F

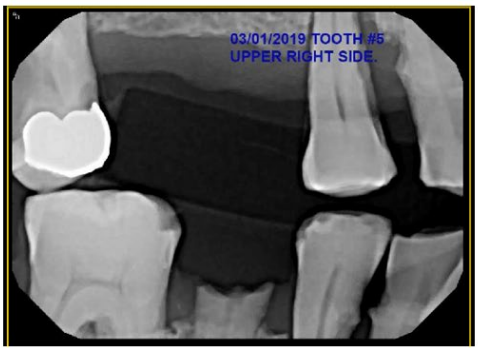
» Gross destruction of crown or root

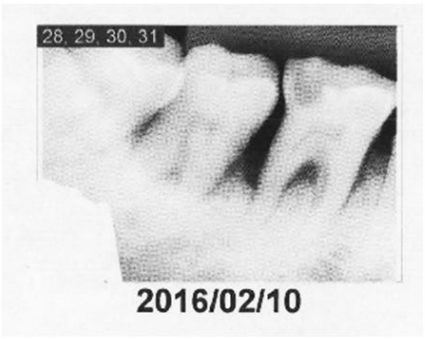




ARC 271A

» Bone loss, mobility, periodontal pathology





9.7 Periodontics

D4346

Scaling in presence of generalized moderate or severe gingival inflammation

- This is considered a global procedure
- Global means it is included in the fee for another procedure and is not payable separately by Medi-Cal Dental
- A global procedure cannot be billed to the member under any circumstance

D4355

Full Mouth Debridement to Enable a Comprehensive Periodontal Evaluation and Diagnosis on a Subsequent Visit

- This procedure is only a benefit for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- A benefit once in a 12-month period
- Not a benefit on the same DOS as D4341, D4342, D1110, or D4910, and not a benefit within 24 months of the last scaling and root planing
- Reminder that this procedure should only be rendered when medically necessary due to heavy calculus, inflammation, etc., to enable periodontal evaluation and should not be billed as though it were an additional prophylaxis

D4341 – D4342

Scaling and Root Planing

- A benefit once per quadrant every 24 months
- Requires
  - Prior authorization
  - Periapical radiographs of all involved teeth in the requested quadrant and bitewings
  - Quadrant code
- Periodontal chart/definitive periodontal diagnosis not required, but will be reviewed if submitted

D4341 – D4342

- Procedure D4341 a benefit when at least four teeth in the quadrant qualify for treatment
- Procedure D4342 a benefit when one, two, or three teeth in the quadrant qualify for treatment

D4341 – D4342

- For pregnant/postpartum members, scaling and root planing can be submitted on a TAR or a claim
- Indicate "pregnant" or "postpartum"
- Requires
  - Periapical radiographs of involved teeth (bitewings can be waived)
  - Quadrant code

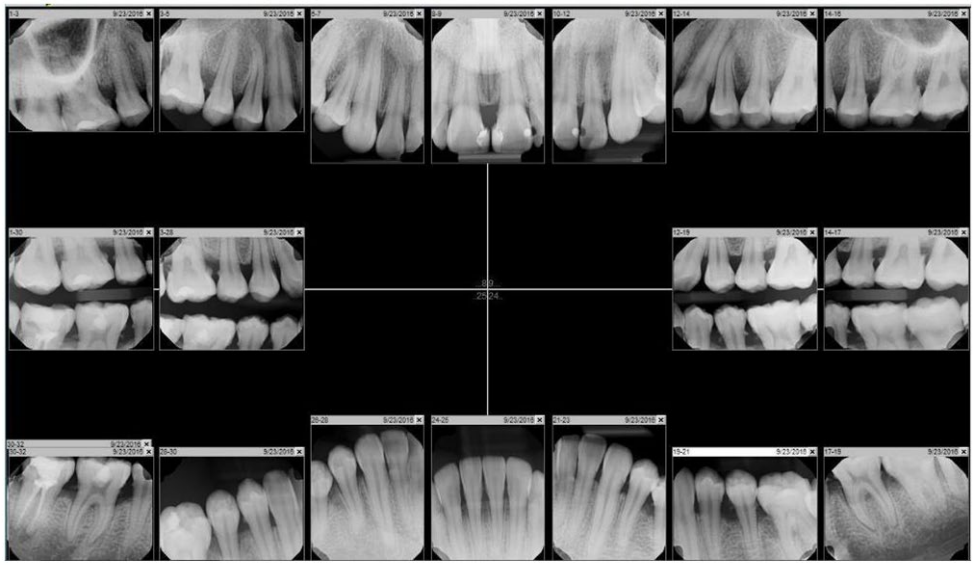
D4341 – D4342

- Only teeth that qualify as diseased are considered in the count for the number of teeth to be treated in a particular quadrant
- Teeth will not be counted as qualifying when they are indicated for extraction

D4341 – D4342

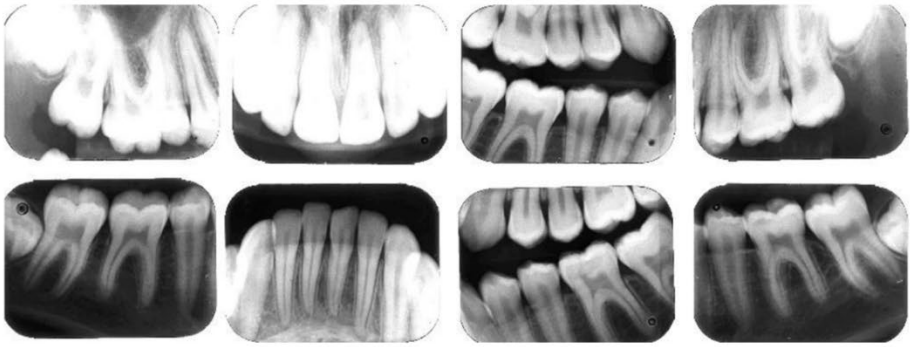
- Each qualifying tooth must show radiographic evidence of:
  - Bone loss
  - Restorability
  - Arch integrity

D4341 – D4342

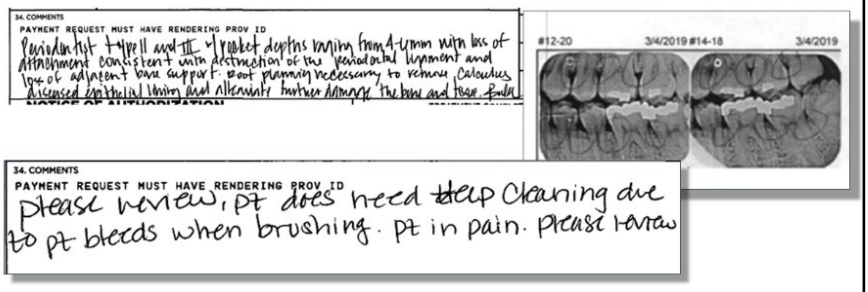


ARC 081

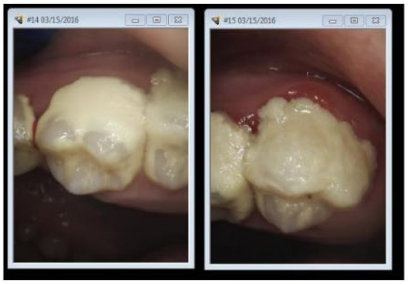
» Based on all submitted documentation, the medical necessity for scaling and root planing (bone loss) has not been established.

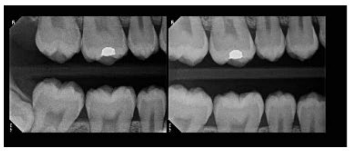


D4341 – D4342



D4341 – D4342





Even with large amounts of calculus on enamel, when accompanied by these radiographs showing no bone loss, this is by definition a prophylaxis case

D4341 – D4342

- Prophylaxis not a benefit on the same date of service as scaling and root planing
- There is no restriction regarding the number of quadrants per date of service

D4910

Periodontal Maintenance

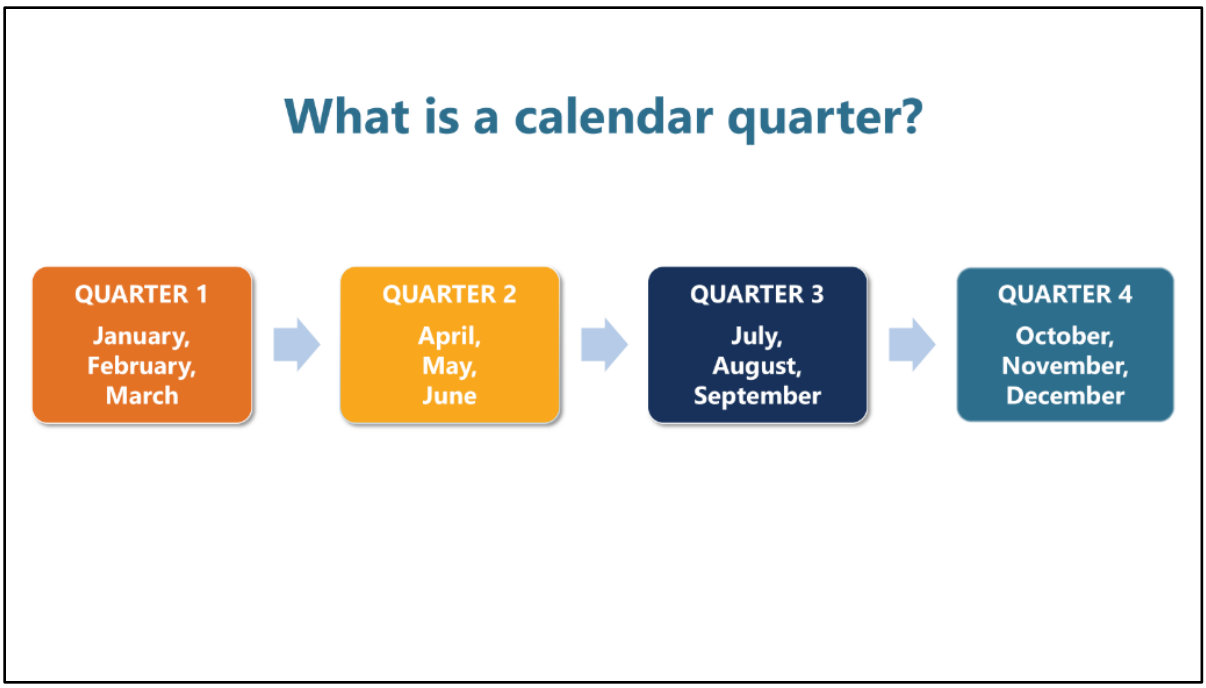
- A benefit for all members
- A full-mouth treatment
- Does not require prior authorization, periodontal charting, or radiographs

D4910

- If Scaling and Root Planing was completed outside of the Medi-Cal Dental Program, submit a ledger and/or chart note with your claim as confirmation of date of service
  - If the member does not qualify for D4341/D4342 based on criteria, they do not qualify for D4910

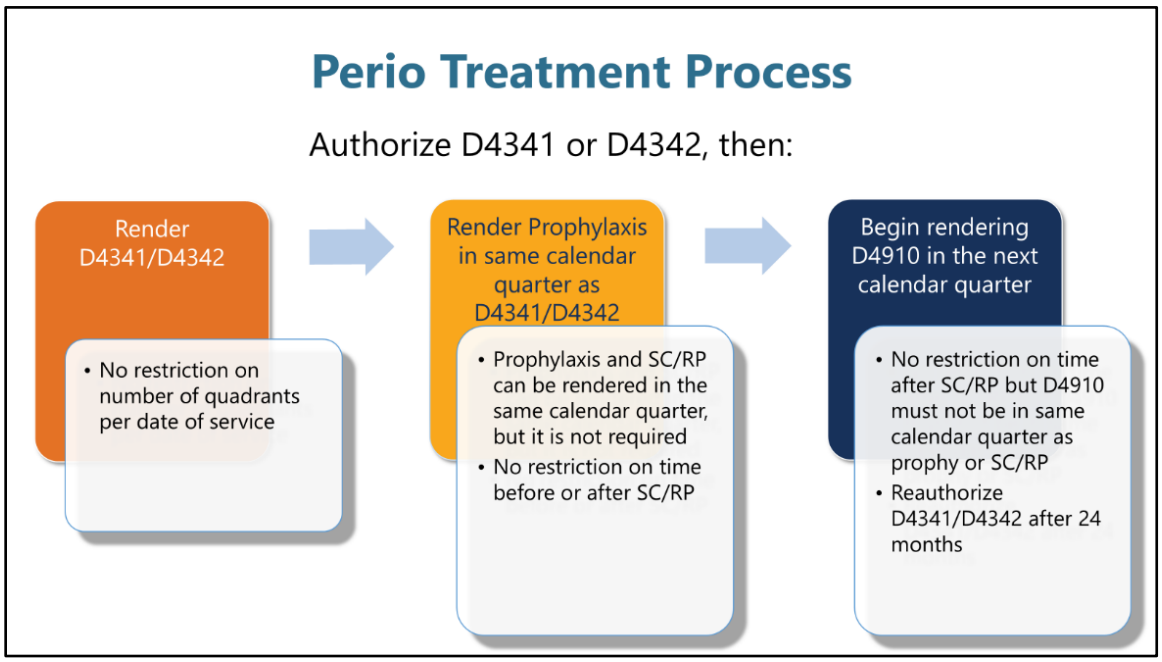
D4910

- A benefit
  - Only when preceded by periodontal scaling and root planing
  - Only after completing all necessary scaling and root planing
  - Only in the 24-month period following the last paid scaling and root planing
  - Once per calendar quarter
- Not a benefit in the same calendar quarter as scaling and root planing, nor in the same calendar quarter as prophylaxis by the same provider



Example: If scaling and root planing is completed in mid-January, a prophylaxis can be done in March, followed by periodontal maintenance (D4910) in April.

9.8 Registered Dental Hygienist in Alternative Practice (RDHAP)



Registered Dental Hygienists in Alternative Practice

» Valid RDHAP procedure codes:

- D0210, D0220, D0230, D0270, D0272, D0274, D0350, D1110, D1120, D1206, D1208, D1310, D1320, D1351, D1354, D2940, D4341, D4342, D4355 (SNF/ICF Only), D4910, D9410, D9920
- CalAIM Caries Risk Assessment (CRA) bundle D0601, D0602, or D0603 with Nutritional Counseling D1310

» RDHAP may bill for radiographs taken in a teledentistry visit even if the exam and teledentistry codes will be billed by a dentist

See the Provider Handbook Section 5 (Manual of Criteria) for more information

Registered Dental Hygienists in Alternative Practice

- Licensed dental hygienists must refer all Medi-Cal Dental patients they treat to a Medi-Cal dentist
- Dental hygienists who do not already have a referral agreement with a Medi-Cal dentist must submit a referral to the Medi-Cal Dental care coordination team
- The referral form is available online on the Medi-Cal Dental website under the "**Care Coordination Referral Form**" link (see link below); this qualifies as a referral once completed

https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/CareCoordinationReferralForm

Registered Dental Hygienists in Alternative Practice

- RDHAP providers should review any Treatment Authorization Requests (TARs) that have been approved and make every effort to be in communication with other providers who are providing treatment to the same patient to ensure appropriate treatment is being provided.
- For example, there have been instances in which a D4355 is rendered by one provider and then a few days later another provider extracts the remaining teeth and delivers dentures

9.9 Removable Prosthodontics

Removable Prosthodontics

Complete Dentures	Resin-Based RPDs	Cast RPDs
D5110 D5120	D5211 D5212	D5213 D5214

- Each of these procedure codes requires:
  - Prior authorization
  - Radiographs of all remaining teeth in both arches
  - A properly completed DC054 form

Removable Prosthodontics

- Immediate Dentures D5130, D5140
  - Prior authorization is not required except when the prosthesis on the opposing arch requires prior authorization
  - Do not require radiograph submission for payment
  - Do not require DC054 form when the removable prosthodontic treatment plan consists of only one arch or consists of two complete immediate dentures
    - When the treatment plan consists of an immediate denture and a partial denture or "remote" complete denture, the immediate denture must be included on the TAR for the complete treatment plan

Removable Prosthodontics

- Complete and partial dentures are prior authorized only as full treatment plans.
  - Payment shall be made only when full treatment has been completed
- Any revision of a prior authorized treatment plan requires a new TAR

Removable Prosthodontics

- Precision attachments and other specialized techniques are included in the fee for the appliance
- The fee includes all adjustments for 6 months
- Relines are a benefit after 6 months if the case involved extractions, and 12 months if did not

Removable Prosthodontics

- A benefit only once in a five-year period
- When adequately documented, the following exceptions apply
  - For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following:
    - a demonstration of continued medical necessity;
    - an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and
    - a clear explanation of the remedial measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

Removable Prosthodontics

- Other considerations include
  - surgical or traumatic loss of oral-facial anatomic structure
  - prosthesis determined to be no longer serviceable by a clinical screening dentist
  - Dentures no longer fitting due to a significant medical condition
    - Requires physician documentation
- Replacement for non-catastrophic loss or misplacement may be granted twice per lifetime. Additional requests beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case-by-case basis.

Removable Prosthodontics

- Use the date prosthesis sent to lab for acrylic processing as the date of service
- Prosthesis must be delivered and in use by member before submitting for payment
- Undeliverable denture payable at 80%
  - Indicate reason for non-delivery
  - Box 44 – Date prosthesis ordered from lab
  - Submit NOA with lab invoice indicating prosthesis was processed in acrylic
  - Keep prosthesis in office in a deliverable condition for one year

D5211 – D5212

Resin base RPDs

- A benefit when replacing a permanent anterior tooth/teeth, or
- The arch lacks posterior balanced occlusion
- D5211 / D5212 do not need to oppose a complete denture to be a benefit of Medi-Cal Dental

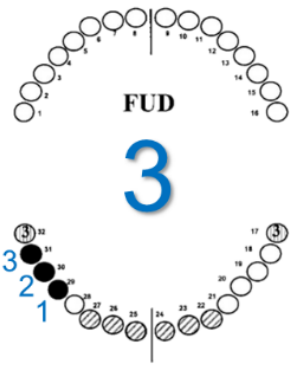
D5213 – D5214

Cast metal framework RPDs

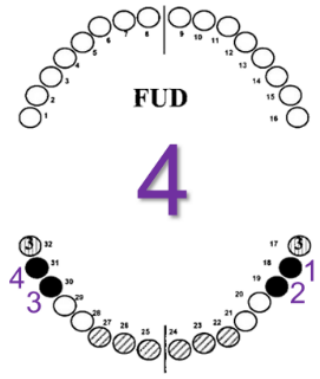
- A benefit only when opposing a full denture and when the arch lacks posterior balanced occlusion

Lack of Posterior Balanced Occlusion

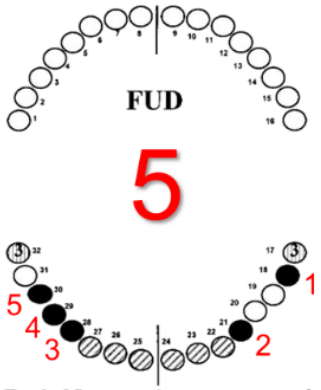
aka "The 3, 4, 5 Rule"



The 1st & 2nd molars and the 2nd bicuspid are missing on the same side.



All four 1st and 2nd molars are missing.



Total of five posterior permanent teeth are missing (excluding 3rd molars).

Justification of Need for Prosthesis (DC054 Form)

- This is the DC054 Form
- Current version is 4/25
- Available as a fillable PDF
- You must submit a prosthetics form to communicate your treatment plan to Medi-Cal Dental

JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ DATE: _____

ADDRESS BOTH ARCHES – COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

MAXILLARY ARCH	MANDIBULAR ARCH
Appliance requested: ☐ FUD ☐ Cast Metal FUD ☐ Resin Base FUD	Appliance requested: ☐ FLD ☐ Cast Metal FLD ☐ Resin Base FLD
☐ Member has never had a maxillary prosthetic appliance	☐ Member has never had a mandibular prosthetic appliance
Has existing appliance: ☐ FUD ☐ Cast Metal FUD ☐ Resin Base FUD Age of appliance? _____ Wears appliance? ☐ Yes ☒ No	Has existing appliance: ☐ FLD ☐ Cast Metal FLD ☐ Resin Base FLD Age of appliance? _____ Wears appliance? ☐ Yes ☒ No
Reason for replacement of maxillary appliance: (Check all boxes that apply) ☐ Worn / Broken Teeth ☐ Loose ☐ Broken Base / Framework ☐ Extraction of Additional Teeth ☐ Other _____	Reason for replacement of mandibular appliance: (Check all boxes that apply) ☐ Worn / Broken Teeth ☐ Loose ☐ Broken Base / Framework ☐ Extraction of Additional Teeth ☐ Other _____
Replacement maxillary appliance is needed due to one of the following: Catastrophic loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.	Replacement mandibular appliance is needed due to one of the following: Catastrophic loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.

Edentulous ☐ Maxillary ☐ Mandibular

☒ Block out missing teeth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
○ Circle teeth to be extracted	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth being replaced: _____
Teeth being cloped: _____

MANDIBULAR ARCH
Teeth being replaced: _____
Teeth being cloped: _____

Does the patient meet the requested services? ☐ No ☐ Yes
Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes

ADDITIONAL COMMENTS PERTAINING TO APPLIANCES/TREATMENT PLAN: _____

Provider Signature: _____

i. Circumstances beyond the control of the patient. For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a description of covered medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient, and (3) a clear explanation of the extended measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structures.

iii. The most viable prosthesis is no longer serviceable as determined by a clinical screening dentist.

iv. Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing dentures cannot be made functional.

v. A non-catastrophic loss or relining/rebasing may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5999 and will be considered on a case by case basis.

DC054 (Rev 04/25)

DC054 Form

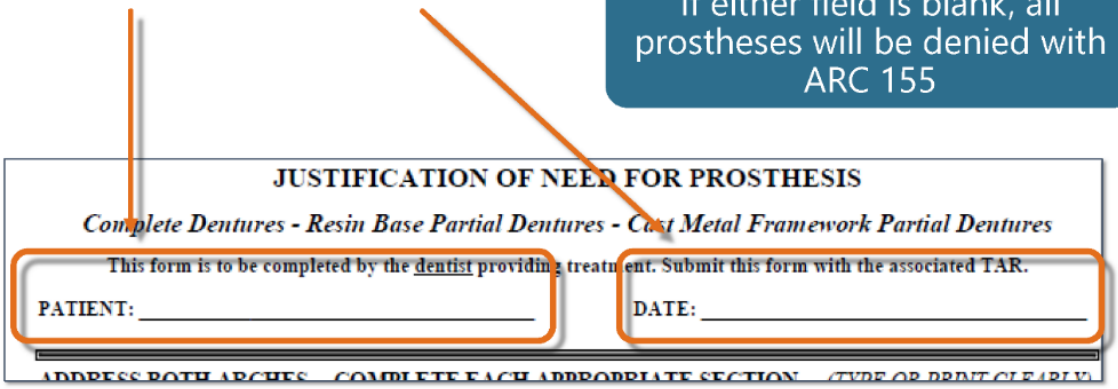
» Documentation must include:

- Both arches
- Missing teeth
- Teeth to be extracted
- Teeth being replaced by the requested partial prosthesis (excluding third molars)
- Teeth being clasped for partial dentures
- Documentation that the patient needs prostheses to chew, eat, etc., is not required

DC054 Form

» Patient name and date form filled are required

If either field is blank, all prostheses will be denied with ARC 155



JUSTIFICATION OF NEED FOR PROSTHESIS

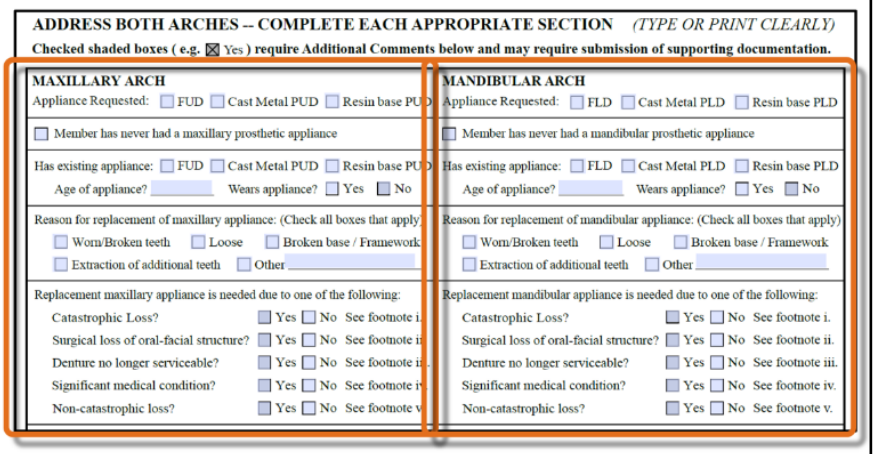
Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ DATE: _____

DC054 Form

- There is a section for the maxillary arch
- And a section for the mandibular arch



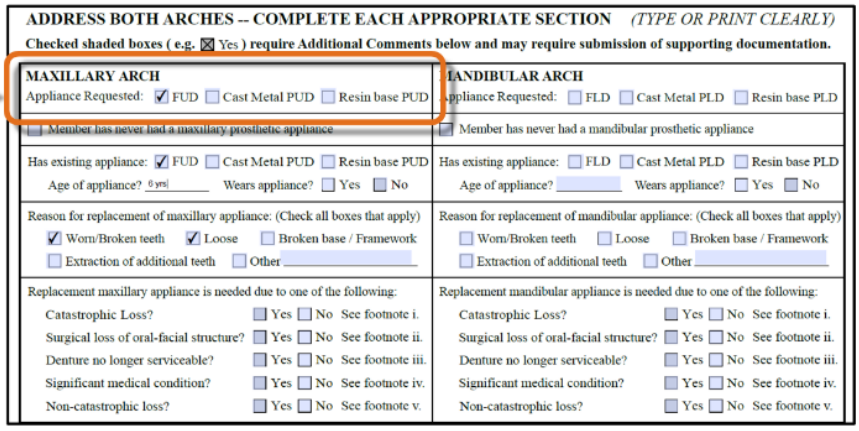
ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

MAXILLARY ARCH	MANDIBULAR ARCH
Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Member has never had a maxillary prosthetic appliance	☐ Member has never had a mandibular prosthetic appliance
Has existing appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD Age of appliance? ____ Wears appliance? ☐ Yes ☐ No	Has existing appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD Age of appliance? ____ Wears appliance? ☐ Yes ☐ No
Reason for replacement of maxillary appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other ____	Reason for replacement of mandibular appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other ____
Replacement maxillary appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.	Replacement mandibular appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.

DC054 Form

- The appliance type requested must have its box checked and must match the procedure code on the TAR



ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

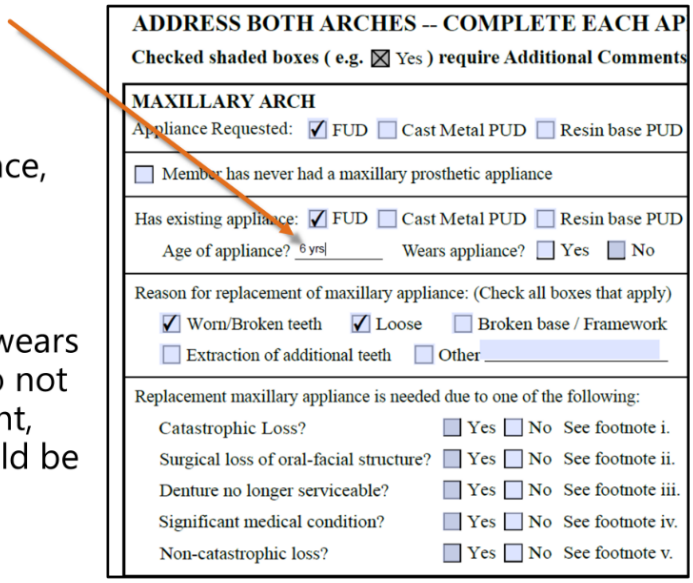
Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

MAXILLARY ARCH	MANDIBULAR ARCH
Appliance Requested: ☑ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Member has never had a maxillary prosthetic appliance	☐ Member has never had a mandibular prosthetic appliance
Has existing appliance: ☑ FUD ☐ Cast Metal PUD ☐ Resin base PUD Age of appliance? 6 yrs ____ Wears appliance? ☐ Yes ☐ No	Has existing appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD Age of appliance? ____ Wears appliance? ☐ Yes ☐ No
Reason for replacement of maxillary appliance: (Check all boxes that apply) ☑ Worn/Broken teeth ☑ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other ____	Reason for replacement of mandibular appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other ____
Replacement maxillary appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.	Replacement mandibular appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.

If the box is not checked or the procedure code does not match the Appliance Requested, procedures can be denied with ARC 155

DC054 Form

- If there is an existing appliance, note the type and age of appliance document why it needs replacement
- If you indicate the member wears an existing appliance and do not indicate need for replacement, the requested appliance could be denied with ARC 268.



ADDRESS BOTH ARCHES -- COMPLETE EACH AP

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments

MAXILLARY ARCH

Appliance Requested: ☑ FUD ☐ Cast Metal PUD ☐ Resin base PUD

☐ Member has never had a maxillary prosthetic appliance

Has existing appliance: ☑ FUD ☐ Cast Metal PUD ☐ Resin base PUD

Age of appliance? 6 yrs Wears appliance? ☐ Yes ☐ No

Reason for replacement of maxillary appliance: (Check all boxes that apply)

☑ Worn/Broken teeth ☑ Loose ☐ Broken base / Framework

☐ Extraction of additional teeth ☐ Other

Replacement maxillary appliance is needed due to one of the following:

Catastrophic Loss? ☐ Yes ☐ No See footnote i.

Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii.

Denture no longer serviceable? ☐ Yes ☐ No See footnote iii.

Significant medical condition? ☐ Yes ☐ No See footnote iv.

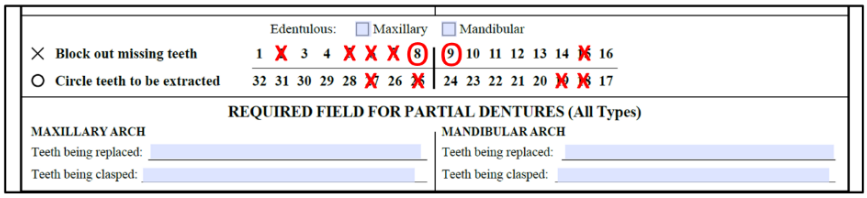
Non-catastrophic loss? ☐ Yes ☐ No See footnote v.

DC054 Form

- You must indicate teeth already missing by crossing them out with an "X" and indicate teeth that are going to be extracted by circling them

You can check the box to mark an arch as currently edentulous rather than crossing out all teeth

Both arches must be accurately addressed, even when an appliance is not requested for the arch



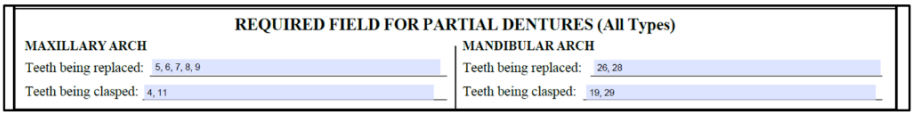
DC054 Form

When an abutment is not 100% depicted the appliance(s) can be denied with ARC 123

- You must list teeth being replaced and teeth being clasped. A tooth being clasped is an abutment and thus requires complete depiction on a radiograph

We will deny the appliance(s) when abutment(s) is/are not depicted at all

Appliances will be denied with ARC 149A or 314C when missing teeth do not or will not qualify for requested appliance

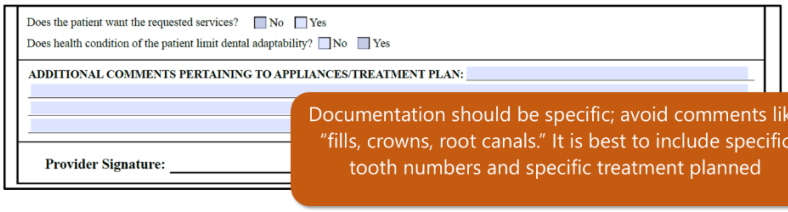


DC054 Form

This is where you should address any pre-prosthetic treatment that is needed and that impacts the design of a partial denture

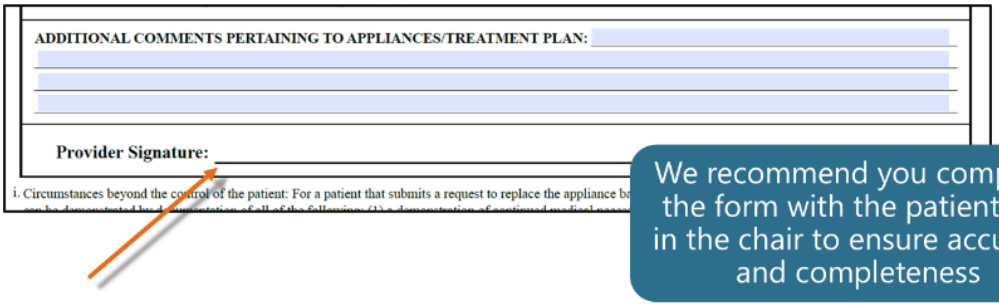
- The Additional Comments field is your opportunity to explain your plan in more detail
- If your patient requires RCT, crowns, or restorations before a partial denture is fabricated, note that here

Special attention should be paid to the abutment teeth – root canals, crowns, and large restorations must be completed or addressed in the Additional Comments field



Documentation should be specific; avoid comments like "fills, crowns, root canals." It is best to include specific tooth numbers and specific treatment planned

DC054 Form



- Finally, the document must be signed by the prescribing dentist and not by other staff.
- License number and/or NPI are **not** required

DC054 Form

i. Circumstances beyond the control of the patient: For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a demonstration of continued medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and (3) a clear explanation of the remedial measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure.

iii. The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

iv. Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing denture cannot be made functional.

v. A non-catastrophic loss or misplacement may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case by case basis.

DC054 (Rev 04/25)

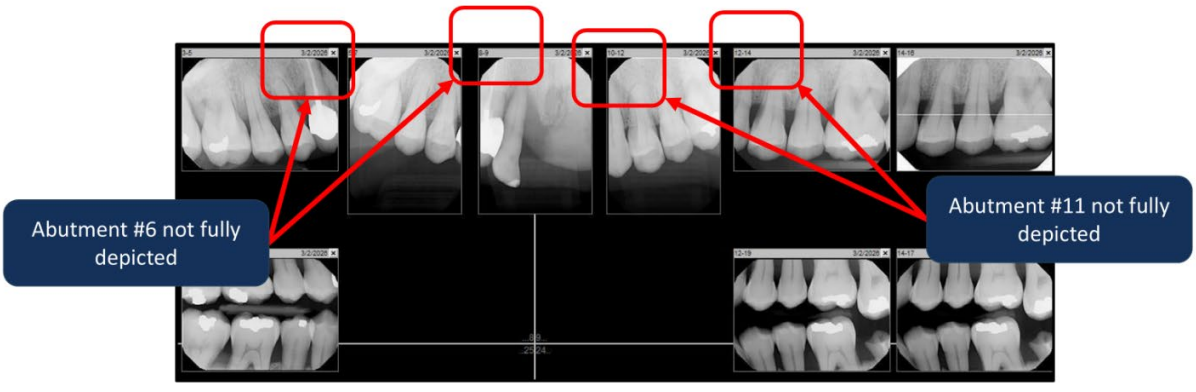
- The latest version of the DC054 form includes advice regarding completion of the form itself to help

ARC 123

- ARC 123: Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
- In the Removable Prosthodontics context, this is often applied when teeth proposed as abutments for the RPD are not fully depicted

ARC 123

- For example, in this case the provider indicated teeth #6 and 11 are to serve as abutments for D5211, but neither abutment is fully depicted



Denture and RPD Adjustments

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Not payable to same provider to 6 months after
  - Delivery of denture
  - Reline
  - Repair
  - Tissue Conditioning

Denture and RPD Repairs

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Do not require
  - Prior authorization
  - Radiographs
  - Documentation

Relines

- A benefit once per 12 months
  - Relines for immediate dentures can occur after 6 months
- D5211 - D5212 do not qualify for indirect reline – only a direct reline
- Do not require
  - Prior authorization
  - Radiographs
  - Documentation

D5850 – D5851

Tissue Conditioning

- A benefit twice in a 36-month period (per prosthesis, not per provider) – Check Medi-Cal Dental treatment history
- Allowable same date of service as insertion of immediate denture
- Does not require:
  - Prior authorization
  - Radiographs
  - Documentation

9.10 Extractions

Extractions

Procedure Code	Description
D7111	Coronal Remnant - primary tooth
D7140	Extraction of erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone or sectioning tooth
D7220	Impacted, soft tissue
D7230	Impacted, partial bony
D7240	Impacted, complete bony
D7241	Impacted, complete bony with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)

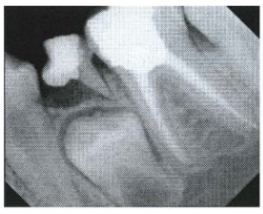
Extractions

- Fee includes:
  - Local anesthesia
  - Sutures
  - Routine post-operative care within 30 days
- Extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars are a benefit
  - To avoid denials for lack of medical necessity, we recommend documenting that extractions were performed as part of orthodontic treatment

D7111

Extraction, coronal remnants, deciduous tooth

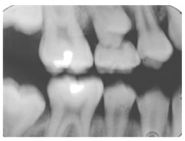
- Documentation/radiographs not required
- Requires tooth number
- Not a benefit for asymptomatic teeth



D7140

Extraction, erupted tooth or exposed root

- Radiographs not required
- Requires a tooth number
- Not a benefit
  - For asymptomatic teeth
  - For root removal by the same billing provider who performed the initial extraction



Radiographs for Extractions

- No radiographs required for D7111 or D7140
- Radiographs required for
  - D7210
  - D7220
  - D7230
  - D7240
  - D7241
  - D7250
- Prior authorization not required for these procedure codes

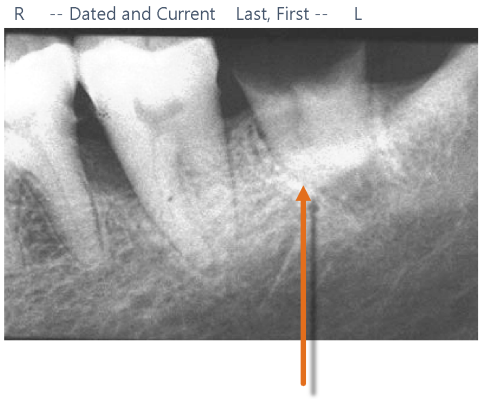
None of these extraction procedure codes requires prior authorization.

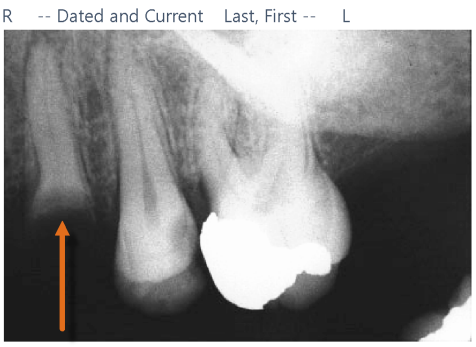
This includes third molars.

D7210

Surgical Removal

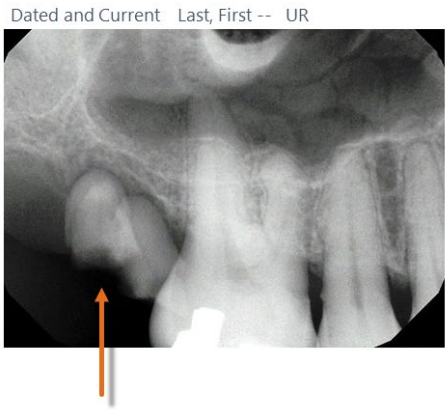
- A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth
- Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal
- When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered



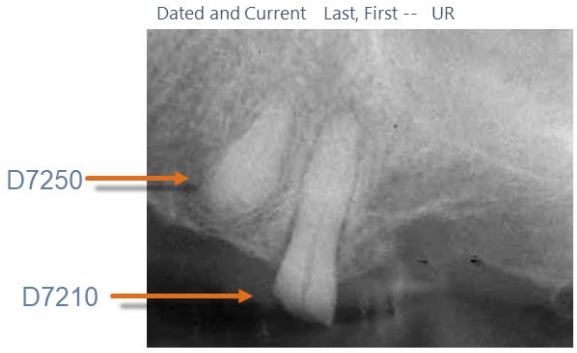


Surgical Removal D7210

- Cases like #17 and #12 qualify for D7210
- If billed as D7140 we would not upgrade
- These do not qualify as D7250



- #2 qualifies only as D7140



- The mesial tooth qualifies as D7250 due to being completely covered by bone on the radiograph
- The more distal tooth qualifies as D7210

Third Molars

- Submit current radiograph depicting the entire tooth
- Prophylactic removal for some adverse condition that may or may not occur in the future is not a benefit
- Consideration for the removal of all third molars will be evaluated when deep sedation/general anesthesia is being utilized with the goal of minimizing multiple exposures to the anesthetic and multiple treatment appointments

D7251

Coronectomy – intentional partial tooth removal, impacted teeth only

- Coronal portion of the impacted tooth (the crown) is removed, and the residual tooth roots are intentionally left in the bone
  - Erupted teeth undergoing decoronation or submergence should be requested as procedure code D3921.
- Prior authorization is required
- Require radiographs
  - Submit current diagnostic, preoperative periapical radiograph, or panoramic radiograph depicting the entire tooth
- Requires documentation
  - Must describe the specific conditions addressed by the procedure and medical necessity
- Requires tooth code

D6100 and D6105

D6100 Surgical removal of implant body

D6105 Removal of implant body not requiring bone removal or flap

- Prior authorization is not required for either procedure code
- Both procedures require radiographs for payment
  - Submit current diagnostic, preoperative periapical radiograph, or panoramic radiograph depicting the implant to be removed.
- Both procedures require tooth code indicating the location of the implant
  - Note: the fee includes the removal of the implant crown
- Procedure Code D6100 requires written documentation to include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity and any pertinent history
  - Procedure code D6105 does not require written documentation

D9930

Treatment of complications (post-surgical) – unusual circumstances by report

- A benefit within 30 days of extraction for the following, but not limited to:
  - Dry socket
  - Excessive bleeding
  - Removal of bony fragment
  - Infection
  - Life-threatening allergy related to recent extraction
- Requires Written Documentation for Payment
  - Shall include the tooth, condition and specific treatment performed

D7922

Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site

- This procedure is considered a "global code"
- Global codes are adjudicated with ARC 269A
  - Included in the fee for another procedure and is not payable separately
  - A global procedure cannot be billed to the member on a private-pay basis under any circumstance when the procedure is paid for by Medi-Cal Dental

9.11 Anesthesia

Anesthesia Procedures

- Administration of nitrous oxide (D9230)
- In-Office administration of minimal sedation- single drug- enteral (D9244)
- Administration of moderate sedation – enteral (D9245)
- Administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof (D9246)
- Administration of moderate sedation – non-intravenous parenteral – each subsequent 15-minute increment, or any portion thereof (D9247)
- Administration of moderate sedation - intravenous
  - D9239 – first 15 minutes
  - D9243 – each additional 15 minutes
- Administration of deep sedation/general anesthesia
  - D9222 – first 15 minutes
  - D9223 – each additional15 minutes

Anesthesia Procedures

General Policies:

- The administration of sedation and therapeutic drug injection D9610 is a benefit
  - In conjunction with payable associated procedures, up to four injections per date of service.
  - Prior authorization or payment shall be denied if all associated procedures by the same provider are denied
- Only the most profound anesthesia paid

D9230

Administration of nitrous oxide

- Any necessary permits and/or endorsements must be on file with Medi-Cal Dental as submitted through the PAVE Portal
- Does not require prior authorization
- No documentation required for members under age 16
- Age 16 or older
  - Documentation is required that indicates physical, behavioral, developmental or emotional condition that prohibits the member from adequately responding to provider's attempt to perform treatment

D9244

In-Office administration of minimal sedation- single drug- enteral

- Any necessary permits and/or endorsements must be on file with Medi-Cal Dental as submitted through the PAVE Portal
- Does not require prior authorization
- Once per date of service
- Requires written documentation
  - For ALL ages– specific anesthetic agent administered, dose and route of administration
  - Age 13 or older – must indicate the physical, behavioral, developmental or emotional condition
- Not payable
  - on the same date of service as other sedation procedures.
  - when all associated procedures on the same date of service by the same provider are denied.

D9245

Administration of moderate sedation – enteral

- Any necessary permits and/or endorsements must be on file with Medi-Cal Dental as submitted through the PAVE Portal
- Does not require prior authorization
- Once per date of service
- Requires written documentation
  - For ALL ages– specific anesthetic agent administered, dose and route of administration
  - Age 13 or older – must indicate the physical, behavioral, developmental or emotional condition
- Not payable
  - on the same date of service as other sedation procedures.
  - when all associated procedures on the same date of service by the same provider are denied.

D9246 – D9247

Administration of moderate sedation – *non-intravenous parenteral*

- Any necessary permits and/or endorsements must be on file with Medi-Cal Dental as submitted through the PAVE Portal
- Does not require prior authorization
- Anesthesia record
- Requires written documentation
  - For ALL ages– specific anesthetic agent administered, dose and route of administration
  - Age 13 or older – must indicate the physical, behavioral, developmental or emotional condition
- Not payable
  - on the same date of service as other sedation procedures.
  - when all associated procedures on the same date of service by the same provider are denied.

Anesthesia Procedures

- Any necessary permits and/or endorsements must be on file with Medi-Cal Dental as submitted through the PAVE Portal
- D9222/D9223 or D9239/D9243 require prior authorization
- Authorization is granted for anesthesia, *not a particular length of time for anesthesia* – additional units of D9223 or D9243 can be added to your Notice of Authorization without additional evaluation on our part
  - When returned, the NOA is always evaluated for the correct quantity and adjusted down if necessary

Anesthesia Procedures

- Providers who render anesthesia shall have valid anesthesia permits with the California Dental Board, and must have their permit on file with Medi-Cal Dental, along with any applicable pediatric endorsement.
- Providers rendering D9222 or D9239 for Medi-Cal Dental members must be enrolled.

Anesthesia Procedures

- For payment, submission of an **anesthesia record** that meets all the documentation requirements mandated by the California Dental Board for anesthesia documentation is required.
- Per the Dental Board of California, moderate sedation, deep sedation, and/or general anesthesia records shall include a time-oriented record with preoperative, multiple intraoperative, and postoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia or deep sedation) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia or deep sedation), drugs (amounts administered and time administered), length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.

D9920 – Behavior Management, By Report

- Cannot be prior authorized
- Requires documentation
  - Member must be an individual with special health care needs
  - Include the medical diagnosis as part of your documentation
  - Document reason for the need of additional time for a dental visit
- A benefit for four visits in a 12-month period
- Only in conjunction with procedures that are payable
- Documentation indicating the patient is a Regional Center Client/DDS Consumer is not sufficient for payment of D9920

D9920 ARCs

- 071A – Not payable when sedation is used as a behavior modification modality
- 071B – Only payable when the member is a special needs member that requires additional time for a dental visit
- 071C – Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit

See Bulletin Volume 35 Number 14
https://dental.dhcs.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_14.pdf

9.12 Early and Periodontic Screening, Diagnostic, and Treatment (EPSDT) Services

EPSDT

Early and Periodic Screening, Diagnostic, and Treatment Services

» In accordance with the Social Security Act and federal regulations, DHCS must provide full-scope Medi-Cal members under age 21 with a comprehensive, high-quality array of preventive, diagnostic, and treatment services under EPSDT

EPSDT

» EPSDT services might or might not be part of the Manual of Criteria

» A service is medically necessary if it corrects or ameliorates defects and physical and mental illnesses or conditions

EPSDT

- A TAR is required when a procedure is not listed in the Manual of Criteria, or a service does not meet the published criteria for a procedure
  - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition

EPSDT 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.

EPSDT Example

- Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planing
- 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