California Medi-Cal Dental





Basic and EDI Seminar Packet



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 Medi-Cal Dental's policies, procedures, and billing requirements. You should also refer to the Medi-Cal Dental Provider Handbook, located on the 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

Medi-Cal Dental

P.O. Box 15609 Sacramento, CA 95852-0609 Phone (800) 423-0507 | www.dental.dhcs.ca.gov State of California Gavin Newsom, Governor

California Health and Human Services Agency

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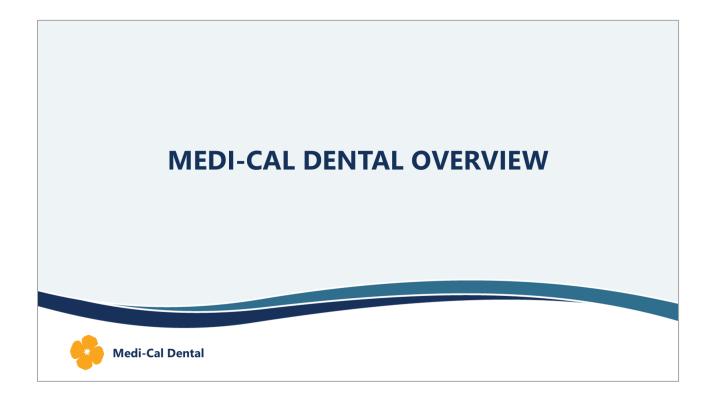
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Introduction

This packet contains the information discussed in today's seminar regarding basic billing procedures and the use of forms. Please refer to Medi-Cal Dental Provider Handbook for detailed, step-by-step instructions on how to complete each form.

When discussing Medi-Cal Dental, some terminology may be unfamiliar. The back of the seminar packet contains a glossary listing some of the terms mentioned in today's seminar.



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

Record Keeping Criteria for Medi-Cal Dental

Medi-Cal Dental's Compliance Management/Surveillance and Utilization Review (CM/SUR) department monitors for suspected fraud, abuse, and poor quality of care. In overseeing appropriate utilization, the CM/SUR department helps Medi-Cal Dental meets its ongoing commitment to improving the quality of dental care for Medi-Cal members.

The goal of the CM/SUR department is to ensure that providers and members are in compliance with the criteria and regulations of Medi-Cal Dental. To achieve this goal, the CM/SUR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. Furthermore, department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard, and/or unnecessary treatment. Refer to the Provider Handbook Section 8 (Fraud) for more information.

Title 22, California Code of Regulations (CCR), established record keeping criteria for all Medi-Cal Dental providers:

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

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

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 40, Number 28 (July 2024) for more information https://dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_40_Number_28.pdf

Additional Services Offered by Medi-Cal Dental

Free Services Offered

- » State-of-the-art Virtual Agent Gabby
 - Providers 800-423-0507 (Toll Free)
 - Members 800-322-6384 (Toll Free)
- » Onsite Training Visits
- » Seminars, Webinars and On-Demand Courses are available with continue education (CE's) credits
- » Case Management and Care Coordination Services
- » American Sign Language (ASL) and Language Services

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

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

www.smilecalifornia.org/partners-and-providers/#provider office language assistance sign

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)

Click here or see the Provider Handbook Section 4 (Treating Members) for more information.

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
Medi-Cal Provider Portal Support Line	800-541-5555
Medi-Cal Website (to verify member eligibility)	mcweb.apps.prd.cammis.medi- cal.ca.gov/
EDI Technical Support	916-853-7373
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 A.V.E.S Help Desk to remove other health care coverage.
- Members may call the Health Care Options number to change managed care.

Telephone Service Center Inquiries

Provider Toll Free Telephone Number

For information or inquiries, providers may call the Telephone Service Center (TSC) toll-free at (800) 423-0507. Providers are reminded to have the appropriate information ready when calling, such as:

- 1. Member Name
- 2. Member Medi-Cal Identification Number
- 3. Billing Provider Name
- 4. Provider Number
- 5. Type of Treatment
- 6. Amount of Claim or TAR
- 7. Date Billed
- 8. Document Control Number
- 9. Check Number

Telephone Service Center Agents are available Monday through Friday between 8:00 am and 5:00 pm, excluding holidays. Providers are advised to call between 8:00 am and 9:30 am, and 12:00 noon and 1:00 pm, when calls are at their lowest level.

Inquiries that cannot be answered immediately will be routed to a Telephone Inquiry Specialist (TIS). The question will be answered by mail within 10 days of receipt of the original telephone call.

Member Toll-Free Telephone Number

If an office receives inquiries from members, please refer them to the Telephone Service Center toll-free member number at (800) 322-6384. The members' lines are available from 8:00 am to 5:00 pm Monday through Friday, excluding holidays.

Either members or their authorized representatives may use this toll-free number. Member representatives must have the member's name, BIC or CIN, and a signed Release of Information form on file with Medi-Cal Dental in order to receive information from Medi-Cal Dental.

The following services are available from Medi-Cal Dental by Member Services toll-free telephone operators:

- 1. A referral service to dentists who accept new Medi-Cal dental members
- 2. Assistance with scheduling and rescheduling Clinical Screening appointments
- Information about Share of Cost (SOC) and copayment requirements of Medi-Cal Dental
- 4. General inquiries
- 5. Complaints and grievances
- Information about denied, modified, or deferred Treatment Authorization Requests (TARs)

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. Providers can access Gabby by dialing the toll-free information line (800) 423-0507 from a touch tone telephone. Gabby is available 24 hours a day, 7 days a week for information that can be accessed without a provider number. 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 hours for accessing information requiring a provider number are Monday through Sunday from 2:00 am to 12:00 midnight. The optimum time to call is between 6:00 am and 10:00 am or between 3:30 pm and 5:00 pm when calls are at their lowest level. 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)

Billing Inquiries and PIN Inquiries

Billing and EFT Inquiries

Please call the Telephone Service Center (TSC) at (800) 423-0507.

- TSC Agents are available Monday-Friday from 8:00 am 5:00 pm
- Excluding State holidays

PIN Confirmation/Reset

A PIN cannot be confirmed or reset over the telephone. To confirm or reset a PIN, send a written request to:

Medi-Cal Dental

PO Box 15609

Sacramento, CA 95852-0609

Medicare/Medi-Cal Crossover Claims

Medicare will pay for certain dental services. See the Medicare/Medi-Cal Crossover Procedure Codes and Descriptions list in the Medi-Cal Dental Provider Handbook for procedures that qualify.

Medi-Cal Dental processes claims and TARs for Medicare covered dental services in accordance with the following Medicare/Medi-Cal crossover policies and procedures:

- A provider must be enrolled with Medicare to bill Medi-Cal Dental for Medicare/Medi-Cal crossover services.
- 2. Medicare must be billed for Medicare covered services prior to billing Medi-Cal Dental. When billing Medi-Cal Dental, attach the EOMB to the claim form.
- 3. Approved and paid Medicare dental services do not require prior authorization by Medi-Cal Dental.
- 4. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a member has no direct bearing on the coverage or exclusion of any given dental procedure.

Hospital Cases

When dental services are provided in an acute care general hospital or a surgery center, the provider must document the need for hospitalization (e.g., developmentally disabled, physical limitations, age, etc.).

To request authorization to perform dental-related hospital services, providers need to submit a TAR with radiographs/photos and supporting documentation to Medi-Cal Dental. Prior authorization is required only for the following services in a hospital setting: fixed partial dentures, removable prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from Medi-Cal Dental, even if the services are provided in an outpatient hospital setting. In all cases, an operating room report, or hospital discharge summary must be submitted with the claim for payment.

Services that require prior authorization may be performed on an emergency basis; however, the reason for the emergency services must be documented. Enclose a copy of the operating room report and indicate the amount of time spent in the operating room.

Hospital Inpatient Dental Services (Overnight or Longer)

If a provider is required to perform services within a hospital setting, the provision of the medical support services will depend on how the member receives their medical services. Members may receive medical services through several different entities:

- Medi-Cal Fee-For-Service (FFS)
- Geographic Managed Care (GMC)
- Medi-Cal Managed Care
- County Organized Health Systems (COHS)

Refer to the Provider Handbook Section 4 (Treating Members) for instructions on how to determine the entity providing a member's medical services.

Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the Medi-Cal (FFS)

Authorization is required by Medi-Cal to admit the member into the hospital.

This authorization must be submitted on the Medi-Cal Form 50-1, which should be sent directly to:

Department of Health Care Services San Francisco Medi-Cal Field Office P.O. Box 3704 San Francisco, CA 94119 (415) 904-9600

NOTE: The Medi-Cal Form 50-1 should not be submitted to Medi-Cal Dental; this will only delay the authorization for hospital admission.

If a member requires emergency hospitalization, a 'verbal' authorization is not available through the Medi-Cal field office. If the member is admitted as an emergency case, the provider may indicate in the Verbal Authorization Box on the Medi-Cal Form 50-1, "Consultant Not Available" (CNA). An alternative is to admit the member as an emergency case and submit the 50-1 retroactively within ten working days to the Medi-Cal field office.

A claim for payment of dental services is submitted to Medi-Cal Dental and must be accompanied by a statement documenting the need and reason the emergency service was performed. Include a copy of the operating room report.

Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans

The dentist must contact the member's medical plan to arrange for hospital or surgical enter admission and medical support services. All medical plans that provide services to Medi-Cal managed care members are contractually obligated to provide medical support services for dental treatment. If the Medi-Cal Field Office receives a Form Medi-Cal Form 50-1 for a Medi-Cal member who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

Mobile Dental Treatment Vans

Mobile dental treatment vans are considered, under Medi-Cal Dental, to be an extension of the provider's office and are subject to all applicable requirements of Medi-Cal Dental.

Maxillofacial-Orthodontic Services (MF-O)

All MF-O surgical and prosthetic services, TMJ dysfunction services, and services involving cleft palate/cleft lip require prior authorization. The exceptions to this are diagnostic services and those services performed on an emergency basis. Providers and their staff should be aware of the procedure codes specific to the MF-O services. To see the codes, refer to the Provider Handbook Section 5 (Manual of Criteria and Schedule of maximum Allowances).

Orthodontic Services

Orthodontic benefits for eligible individuals under the age of 21 are available under California Medi-Cal Dental when medically necessary. Services must be performed by a qualified orthodontist who is enrolled as a Medi-Cal Dental provider. Medi-Cal Dental covers handicapping malocclusion, cleft palate/lip, and cranio-facial anomalies cases. A Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet must be submitted to document the medical necessity. All Forms are located on the Medi-Cal Dental Website. Refer to the Provider Handbook Section 9 (Special Programs) for more information about Orthodontic benefits.

California Children's Services (CCS)

CCS provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition. Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS for an evaluation.

All CCS dental/orthodontic providers must be enrolled and active in Medi-Cal Dental prior to receiving payment. If a provider has a valid authorization issued by CCS, the authorization will be honored through the expiration date. Continue using the same processing guidelines that were in place when the services were authorized.

CCS Guidelines

All CCS members are subject to the scope of benefits, prior authorization and processing guidelines as defined in the Medi-Cal Dental Provider Handbook. CCS only authorizes dental services if such oral conditions affect the member's/CCS-eligible condition. Refer to the Provider Handbook Section 9 (Special Programs) for more information.

CCS/Medi-Cal Authorizations and Claims Processing

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

CCS/Medi-Cal claims and TARs are to be sent directly to Medi-Cal Dental. Providers may submit a TAR requesting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for a Medi-Cal member requiring dental benefits beyond the scope of Medi-Cal Dental.

CCS Only

CCS eligible members will continue to require service authorization requests (SARs) from CCS. Providers must request a SAR from the CCS county or regional office prior to submitting claims and TARs to Medi-Cal Dental.

The Professional Component

Medi-Cal Dental has a professional unit consisting of dental consultants who are also licensed dentists. The consultants review all claims and TARs which require professional judgment. These dental consultants assist Medi-Cal Dental Provider/Member Services and Clinical Screening departments with reevaluations and special cases.

In addition, there are clinical screening dentists located throughout the state. They are responsible for pre-screening cases that may require clinical evaluation under the guidelines of Medi-Cal Dental.

After the clinical screening dentist has examined the patient, a Medi-Cal dental consultant reviews the screening report. The claim or TAR is subsequently approved, modified, or denied. Medi-Cal Dental clinical screening dentists also do post-operative screenings.

Onsite Training 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.

Seminars, Webinars, and On Demand Trainings

Medi-Cal Dental provides a range of free training opportunities including seminars and webinars. These cover topics from Basic and Advanced levels. These include EDI (Electronic Data Interchange) Workshop (combined basic and advanced sessions) and Orthodontic services. On-Demand training is also available through a secure personal account on the Learning Management System (LMS), allowing you to complete courses at your own pace. All training courses are free and offer continuing education credits based on the number of hours completed. To view a list of available training courses, visit Medi-Cal Dental website

https://www.dental.dhcs.ca.gov/Providers/Medi Cal Dental/Provider Training/ProviderTraining

Case Management

Dental Case Management is available for those members who are unable to schedule and coordinate complex treatment plans involving one or more medical or dental providers. Case management services are intended for members with significant medical, physical, and/or behavioral diagnosis or diagnoses. Referrals for case management services are initiated by the member's medical provider, dental provider, case worker or healthcare professional and are based on a current, comprehensive evaluation and treatment plan.

The Case Management referral form is located on the Medi-Cal Dental website: www.dental.dhcs.ca.gov under Dental Case Management. Members must be referred by a Medical or Dental professional by completing the secure online referral form. If you have questions when submitting an online referral, please contact the Telephone Service Center at (800) 423-0507. Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Care Coordination Services

Care Coordination services are offered by the Telephone Service Center (TSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our TSC agents, who assist members with: Locating a General or Specialist Dentist, Accessing Appointments, Translation Services, Transportation Assistance. Members can access the Care Coordination Services by contacting the Telephone Service Center at (800) 322-6384, and request Care Coordination assistance.

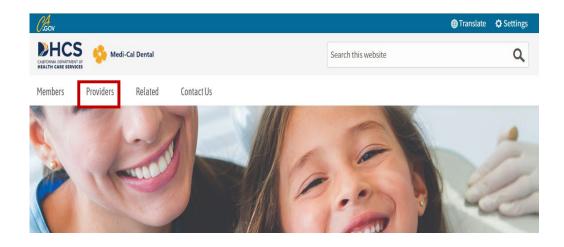
The Medi-Cal Dental Provider Website

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 assists 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.

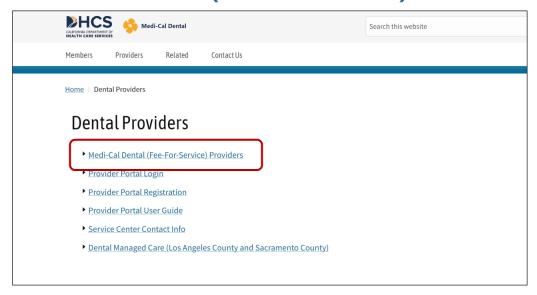
The Medi-Cal Dental Bulletins are published periodically to keep providers informed of the latest developments. New bulletins will appear in the "What's New Section" of the Medi-Cal Dental website and are incorporated into the "Provider Bulletins" section of the website. This section should be checked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

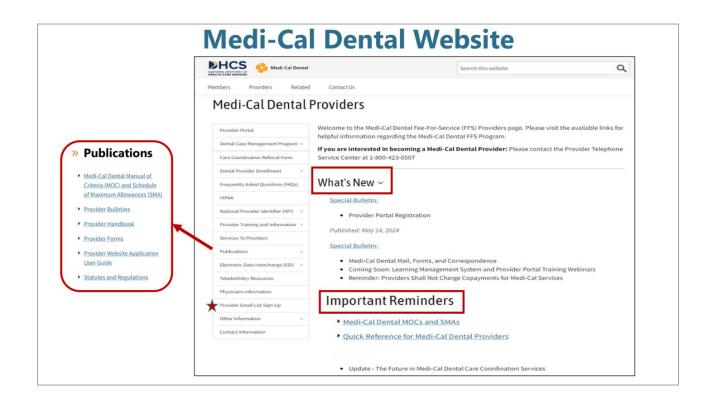
Medi-Cal Dental Provider Website



www.dental.dhcs.ca.gov

Medi-Cal Dental (Fee-For-Service) Providers





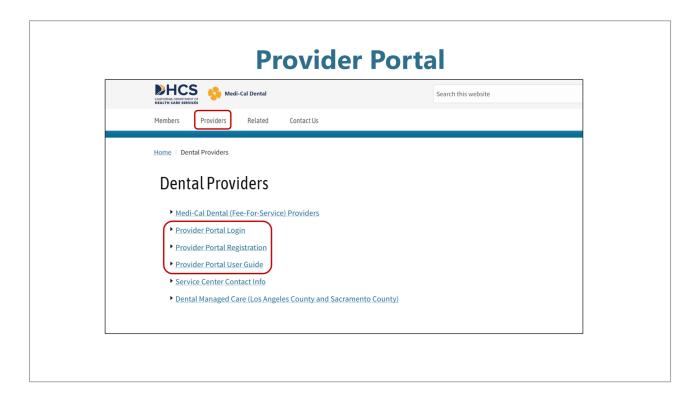
Medi-Cal Dental Provider Portal

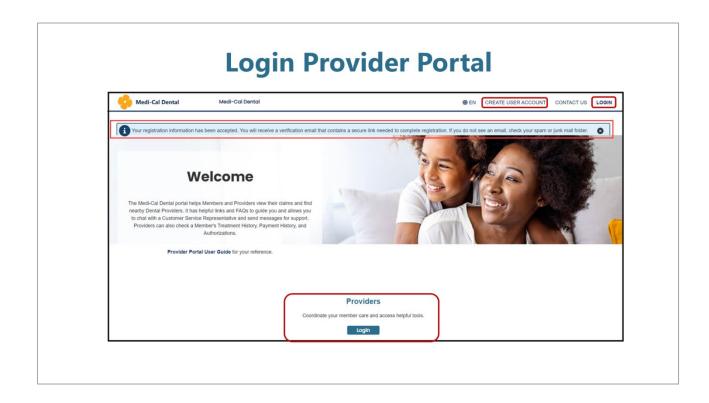
Registered providers can check Medi-Cal Dental member's history online. This feature will display all dental services that a member received from Medi-Cal dental providers in the last five years, with individual provider information hidden. Each line item will include:

- Tooth information
- Procedure(s)
- Dates of service
- Denied/allowed status

Providers can also use the Provider Portal to access other important Medi-Cal Dental information, such as:

- Claim status and history
- Treatment Authorization Request status and history
- Weekly check amounts
- Monthly payment totals and year-to-date payment





Enrollment

Enrollment: Become a Medi-Cal Provider

- » To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in Medi-Cal Dental
- » Enrollment is through the Provider Enrollment Division (PED) of DHCS
 - PED uses an online application portal called the Provider Application and Validation for Enrollment (PAVE)
 - Paper applications are <u>not</u> accepted!

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

Provider Application and Validation for Enrollment (PAVE) Portal

- » Enrollment:
 - PAVE is for Providers who want to enroll in Medi-Cal Fee-for-Service
- » Enrollment Changes:
 - All changes to your practice and/or license must be completed through PAVE
 - This must happen within 35 days of the change
- » Enrollment Revalidation
 - DHCS will notify providers when revalidation is necessary

Enrollment: Welcome Packet

- » Newly enrolled billing provider receives:
 - Billing Provider Number
 - Personal Identification Number (PIN)
 - Starter packet of forms
 - Re-order additional forms on the Medi-Cal Dental Website



Enrollment: Revalidation Process

- » State regulations mandate that all providers are required to re-validate every 5 years to continue participating in Medi-Cal Dental
- » DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application
- » Dental providers submit revalidation applications using PAVE
- » https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

See PED website or PED Message Center for more information.

Electronic Funds Transfer (EFT)

Request direct deposit through PAVE

Funds are deposited directly into your bank account on Tuesday night

Notice of deposits will appear on the Explanation Of Benefits (EOB)

Billing Providers

To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in Medi-Cal Dental. On October 31, 2022, DHCS implemented the <u>Provider Application and Validation for Enrollment (PAVE) Provider Portal</u> to simplify and accelerate Medi-Cal enrollment processes for dental providers. The PAVE portal is a web-based application that allows dental providers to submit enrollment applications and required documentation to DHCS electronically.

PAVE website: Provider Enrollment Division (PED) (ca.gov)

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

Once the enrollment process is complete, the new Billing Provider will be informed of acceptance into Medi-Cal Dental which will include the Billing Provider number and a Personal Identification Number (PIN).

The new Billing Provider will also receive a starter packet of forms. Additional forms may be ordered by completing the Forms Re-order Request form found on the Medi-Cal Dental Website. Medi-Cal Dental Forms Reorder Request

Rendering Providers

Each provider who treats Medi-Cal members must be enrolled in Medi-Cal Dental. The Rendering Provider number will be the type 1 NPI number that the Dr. obtained from NPPES. Group and rendering providers will be required to complete an affiliation form within PAVE. The Rendering Provider number will be entered in Box 33 on your Claims and NOAs.

Billing Intermediaries

Medi-Cal Dental accepts claims prepared and submitted by a billing service acting on behalf of a provider. The provider and billing service must complete the Medi-Cal Dental Provider and Billing Intermediary Application/Agreement found on the Medi-Cal Dental website. Once the process is complete, the billing service will receive a registration number which must be included on all claim forms they submit on a doctor's behalf.

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
- Email <u>PAVE@dhcs.ca.gov</u>
- 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 – 6:00 pm

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

Eligibility

Eligibility

- » Eligibility is established by the County Department of Social Services
 - Information is transferred to the Department of Health Care Services (DHCS)
- » Benefits Identification Card is issued
- » Eligibility is established on a monthly basis
 - Providers must verify a member's eligibility for each month the member is receiving services
- » Eligibility Verification Confirmation Number (EVC)

https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

Members Turning 21 Years of Age

- » Benefit changes on the day the member turns 21
- » Authorization for services that were approved prior to the member's 21st birthday, may still be provided as long as:
 - The member continues to have Medi-Cal eligibility;
 - The procedures were approved; and
 - Prior to January 29, 2025, the service must be completed within the 180 days window as allowed on the Notice Of Authorization (NOA).
 - Approved NOAs and denied NOAs submitted for re-evaluations, processed on and after January 29, 2025, once approved, will be authorized for 12 months (365 days) to complete the treatment for all procedure codes.

Click here or see Bulletin Volume 40 Number 42 for more information

Medi-Cal Members Identification

The Benefits Identification Card (BIC) is a permanent plastic card issued by the county in which the member resides. The front of the card contains the member's ID number, name, birth date, and issue date. The reverse side contains a magnetic strip and member's signature area. If a card is lost or stolen, refer the member to the county office. List of county office can be found at this link https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

Verifying Member Identification

Members are required to sign their Benefits Identification Card (BIC) prior to presenting the card for services. Members who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. If a provider does not attempt to identify a member and provides services to an ineligible member, payment for those services may be disallowed. In certain instances, no identification verification is required, for example:

- When the member is 17 years of age or younger
- When the member is receiving emergency services
- When the member is a resident in a long-term care facility

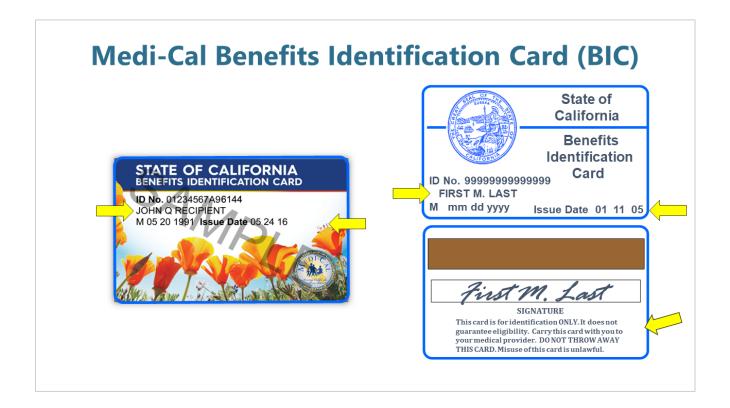
If the member is unknown to the provider, the provider is required to make a "good-faith" effort to verify the member's identification by matching the name and signature on the Medi-Cal issued ID to that on a valid photo identification, such as:

- A California driver's license
- An identification card issued by the Department of Motor Vehicles
- Any other document which appears to validate and establish identity

Medi-Cal dental providers must now accept expired photo identification (ID) up to six months from the date of expiration to verify a Medi-Cal patient's eligibility. During this grace period, providers may not deny Medi-Cal patients service for an expired ID.

NOTE: The provider must retain a copy of this identification in the member's records.

Any provider who suspects a member of abusing Medi-Cal Dental may call (800) 822-6222, Monday through Friday between 8:00 am and 5:00 pm



Medi-Cal Benefits Identification Card (BIC)

- » The Benefits Identification Card contains information to enable providers to access eligibility
 - · NOT a verification of eligibility
 - NOT guarantee for payment
 - Make a copy of the BIC for the member record
- » Verification of Identification
 - All paper cards (Immediate Need, CHDP, Presumptive Eligibility Cards) are used for ID purposes only.
 - Make a copy of the ID for the member record
 - Verification of Identification Exceptions

Verifying Eligibility

- » Medi-Cal verifies member eligibility
 - Verify eligibility and current Share of Cost (SOC) information
- » The Medi-Cal Provider Portal is available 22 hours a day, 7 days a week
- » By touch-tone telephone 800-456-2387
 - Automated Eligibility Verification System (AEVS)
 - · Then enter the assigned 6-digit PIN
- » By internet access https://mcweb.apps.prd.cammis.medi-cal.ca.gov/
 - Provider Portal
 - · Login to Provider Portal
 - Enter the Email Address and Password Created
 - Eligibility printout/download should be maintained in the member's record

Request Access to the Eligibility Website

- » Providers must register in the Medi-Cal Provider Portal
 - Medi-Cal website: https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/login
- » Providers may be required a token to register
- » A token must be requested directly to Medi-Cal services for assistance Medi-Cal Dental Providers can call 1-800-541-5555

Verifying Eligibility

Providers must verify eligibility every month for each member who presents a BIC, paper Immediate Need or Minor Consent card. A provider who declines to accept a Medi-Cal member must do so before accessing eligibility information with the exceptions listed in the Handbook. The State of California Department of Health Care Services (DHCS) will also review claims to determine providers who establish a pattern of providing services to ineligible members or individuals other than the member indicated on the BIC.

Options to Access Eligibility and Share of Cost (SOC)

To verify eligibility and complete an SOC transaction, access is available through the following methods:

Touch-tone Telephone Access

With the use of an assigned PIN, all providers with a touch-tone telephone may access the Medi-Cal Automated Eligibility Verification System (AEVS). The automated system will provide eligibility and SOC information that is current and up to date. AEVS is accessible 22 hours a day, 7 days a week. The toll-free number to access AEVS is (800) 456-AEVS (2387). Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Internet Access

The Medi-Cal website mcweb.apps.prd.cammis.medi-cal.ca.gov/ allows providers to verify eligibility and update Share of Cost liability. Medi-Cal providers will need to register for the Provider Portal at https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/login.

For further assistance, contact the Telephone Service Center (TSC) at 1-800-541-5555.

Eligibility Verification Confirmation (EVC)

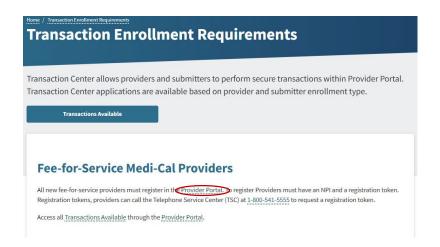
If the member's eligibility has been established for the month requested, an EVC number is received. This number should be recorded in the patient record. Please enter the EVC number in the field available on the Treatment Authorization Request (TAR)/Claim form, or in Box 23 on the Notice of Authorization (NOA).

Medi-Cal Home Page mcweb.apps.prd.cammis.medi-cal.ca.gov/

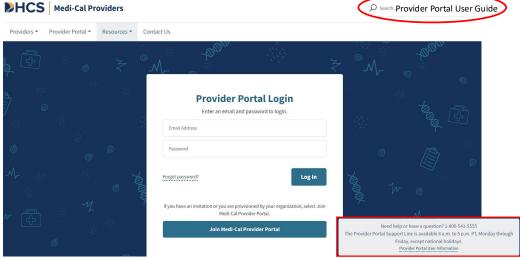


Provider Portal – Enrollment Requirements

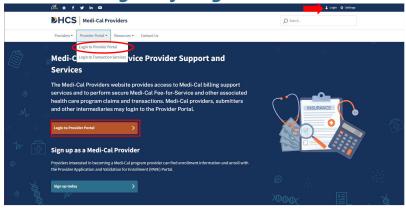


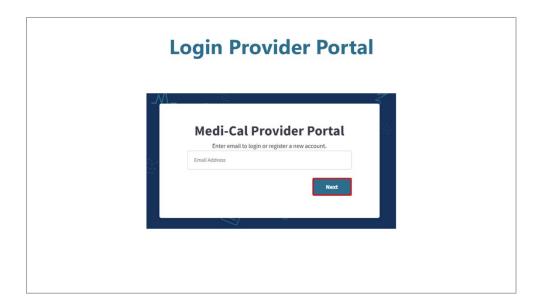


Provider Portal Resources PHCS | Medi-Cal Providers | Provider | Providers | Provider | Prov

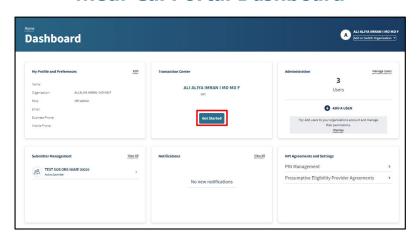


Web Eligibility: Login Provider Portal

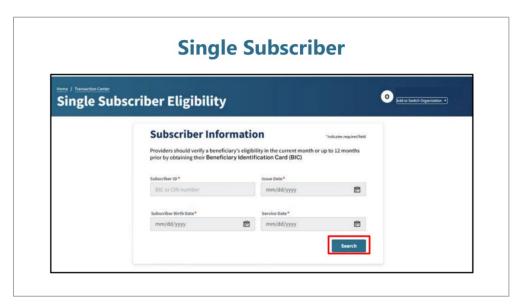


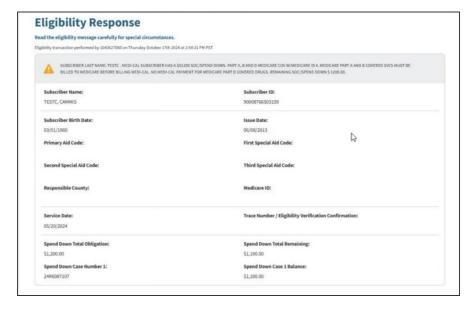


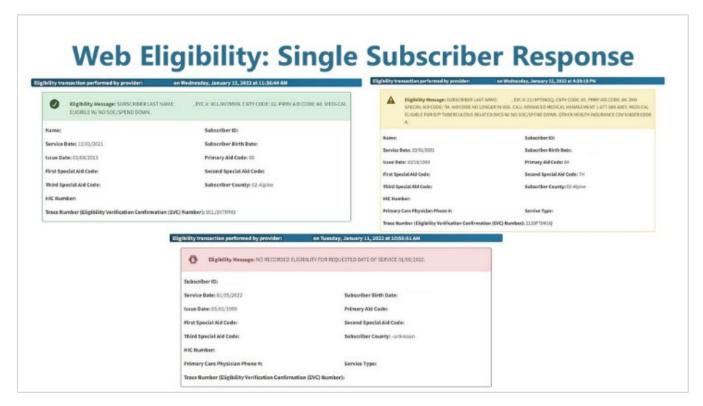
Medi-Cal Portal Dashboard



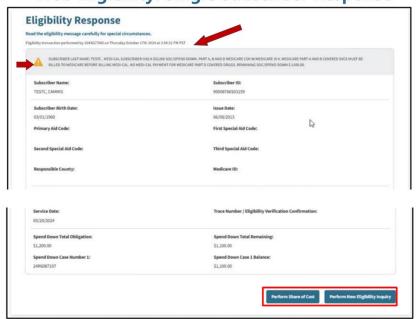






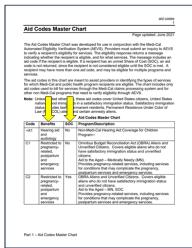


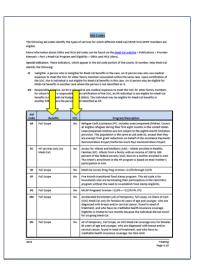
Web Eligibility: Single Subscriber Response



Aid Code Master Chart

- » The Aid Code Master Chart lists each Aid Code with columns for:
 - Type of Benefits
 - Share of Cost

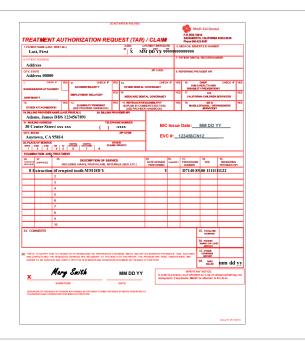




See the Provider Handbook Section 4 or the Medi-Cal website for the Aid Code Master Chart.

Aid Codes

- » Not everyone receiving Medi-Cal has full-scope benefits:
 - Limited Services
 - Restricted Services



Limited Services = Aid Codes that are limited to specific services only (i.e. cancer services

Restricted Services = Aid Codes that are restricted to specific services only (i.e. emergency services only)

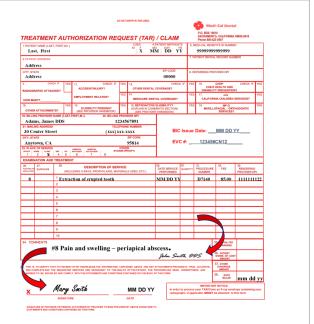
Emergency Services

Emergency Services require:

- » Emergency Certification Statement
- » Two signatures

Emergency services aid codes for OBRA members:

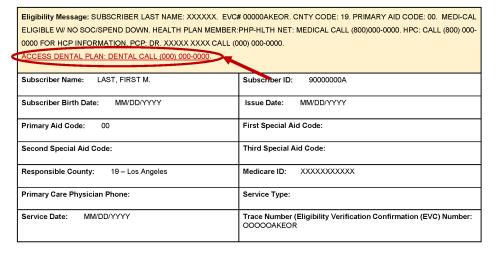
» Must contain specific emergency procedures, regardless of age.



Click here or see the Provider Handbook Section 10 Table 4 for a list of allowable procedure codes.

Managed Care Plans

» Patient must go to a plan provider:



Other Insurance Coverage

- » Prepaid Health Plans (PHP) / Health Maintenance Organization (HMO)
- » Indemnity Plans
- » Medi-Cal Dental is always secondary carrier
- » Other Coverage must be billed first

	XXXXX. EVC# 00000AKEOR. CNTY CODE: 11. PRIMARY AID D DOWN. OTHER HEALTH INSURANCE COV. UNDER CODE IN DXXXX000XXX00. COVEMIPDED
Subscriber Name: LAST, FIRST M.	Subscriber ID: 90000000A
Subscriber Birth Date: MM/DD/YYYY	Issue Date: MM/DD/YYYY
Primary Aid Code: 00	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Responsible County: 11- Glenn	Medicare ID: XXXXXXXXXXX
Primary Care Physician Phone:	Service Type:
Service Date: MM/DD/YYYY	Trace Number (Eligibility Verification Confirmation (EVC) Number: OOOOOAKEOR

Share of Cost (SOC)

- » Share of cost is a preset dollar amount that is determined by DHCS for an individual or for a family
 - This amount must be met each month before the member is eligible for Medi-Cal benefits
 - Any health care services, including non-covered services, may be used to meet SOC
- » Only update SOC for services that are performed in your dental office
- » Payment for the SOC is based on the provider office policy and the member

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

Case Numbers

- » Case numbers indicate the member is part of a family SOC
- » SOC Case Summary Report
 - Provided by the member's social worker or local county office
 - Indicates all family members involved
- » Benefits may not be received by all in SOC
- » No Eligibility Aid Codes:
 - IE Ineligible
 - OO No Aid Code
 - RR Responsible Relative

250 Percent Working Disabled Program

- » Members with aid code 6G
- » The "Spend Down Obligation Amount" field is due to the 250 Percent Working Disabled Program, the message will state that the recipient is eligible for full-scope Medi-Cal
- » The SOC amount is a premium that the recipient pays directly to the Department of Health Care Services (DHCS)
- » Effective 7/1/2022 the reduction to premiums will be zero (\$0)
- » www.dhcs.ca.gov/services/Pages/TPLRD WD cont.aspx

Updating Share of Cost thru the POS Network

EXAMPLE: Member share of cost is \$87.00

Description	Date of Service	Procedure Code	UCR Fee	Member Portion
Examination	MM DD YY	D0150	\$40.00	\$40.00
2 Bitewings	MM DD YY	D0272	\$27.00	\$27.00
Prophy	MM DD YY	D1120	\$60.00	\$20.00
Total			\$127.00	\$87.00

THEN: Submit a claim to Medi-Cal Dental for all services provided.

Member Dental Cap

- » \$1800.00 Calendar year maximum
 - Applies to adults only (21 years and over) s relaxed
 - Children are exempt (thru age 20)
- » Exclusions to the Cap:
 - Emergency dental services
 - Dentures
 - Maxillofacial and complex oral surgery
 - Services principal for long-term care aid codes
 - Service rovided to residents of SNFs or ICFs
 - Federally mandated services (including pregnancy-related services)

Benefits Table Guide

Age / Aid Code	Full Scope Benefits	Section 4 Provider Handbook
Full Scope aid code		
Child (under 21)		
Adult (21 and over)	x	
 Member resides in an ICF or SNF 		
DDS Member		
Emergency/Pregnancy aid code		
All ages		x
 Member is NOT pregnant/postpartum 		
Member is <u>pregnant/postpartum</u>	×	
(regardless of age and aid code)	^	

Residents of Qualifying SNF, ICF, ICF-DD, ICF-DDH and ICF-DDN

- » These members are eligible for additional services
- » Services do not have to be provided in the facility to be payable
- » All services provided in a SNF or ICF require prior authorization except for diagnostic services and emergency procedures
- » Not all facilities qualify; therefore, use the website to confirm the classification and licensing of a facility:

https://www.cdph.ca.gov/programs/chcq/calhealthfind/Pages/Home.aspx

Pregnant Members

- » Pregnant members, regardless of age, aid code and/or scope of benefits, are eligible to receive all dental procedures listed in the Manual Of Criteria (MOC)
- » Includes 12 months of postpartum
- » All requirements and criteria must be met
- » Must document Pregnant or Postpartum

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, and program and payment reform across the Medi-Cal program
- » 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

- » Preventative Services: Pay for Performance (P4P)
- » Caries Risk Assessment and Silver Diamine Fluoride Benefits
- » Continuity of Care: Pay for Performance (P4P)

Preventative Services: Pay for Performance (P4P)

- » P4P to increase statewide utilization of preventive services
- » Performance payments will be included in the weekly check write for all qualified paid preventive services
- » A performance payment at an additional 75% of the SMA
- » SNC claims will need to be validated for qualifying codes prior to issuing payment
 - Performance payments are earned and paid to SNC locations once a month

PREVENTIVE SERVICES PAY FOR PERFORMANCE FEE SCHEDULE											
PROCEDURE CODE	CODE DESCRIPTION	CURRENT SMA	PERFORMANCE PAYMENT	MEMBERS UNDER AGE 21	MEMBERS UNDER AGE 18	MEMBERS OVER 21					
D1120	PROPHYLAXIS	\$30.00	\$22.50	Х							
D1206	TOPICAL APPLICATION OF FLUORIDE - VARNISH (CHILD 0 TO 5)	\$18.00	\$13.50	Х							
D1206	TOPICAL APPLICATION OF FLUORIDE - VARNISH (CHILD 6 TO 20)	\$8.00	\$6.00	Х							
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH (CHILD 0 TO 5)	18.00	\$13.50	Х							
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH (CHILD 6 TO 20)	\$8.00	\$6.00	Х							
D1351	SEALANT - PER TOOTH	\$22.00	\$16.50	Х							
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT - PERMANENT TOOTH	\$22.00	\$16.50	Х							
D1510	SPACE MAINTAINER - FIXED - UNILATERAL - PER QUADRANT	\$120.00	\$90.00		Х						
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$200.00	\$150.00		Х						
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$200.00	\$150.00		Х						
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$230.00	\$172.50		Х						
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$230.00	\$172.50		Х						
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	\$30.00	\$22.50		Х						
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	\$30.00	\$22.50		X						
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	\$30.00	\$22.50		Х						
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT	\$30.00	\$22.50	Х							
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY	\$30.00	\$22.50	Х							
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR	\$30.00	\$22.50	Х							
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL - PER QUADRANT	\$120.00	\$90.00		Х						
D1320	TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE	\$10.00	\$7.50			Х					
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT.	\$46.00	\$34.50			Х					

Caries Risk Assessment (CRA)

- » CRA bundle includes the allowable increased frequencies for moderate and high-risk CRA bundles as a statewide dental benefit in alignment with national dental care standards
- » To receive payment for the CRA bundle, dental providers must take the Treating Young Kids Everyday (TYKE) training hosted by the California Dental Association (CDA)
 - Providers will need to complete an attestation form and provide proof of TYKE training
 - Providers with an active status that have completed an attestation form and TYKE training during DTI domain 2 are not required to complete these again

Caries Risk Assessment (CRA) Bundle

- » CRA bundles are based on the risk level associated with each Medi-Cal member, ages 0-6 only
- » Bundle includes:
 - Caries Risk Assessment: D0601, D0602, D0603 (\$15.00)
 - Nutritional counseling: D1310 (\$46.00)
- » Additional services such as cleaning, fluoride, and exam can be rendered based on the risk level

CalAIM Benefit: Caries Risk Assessment Bundles

	CARIES RISK ASSESSMENT (\$15.00)	NUTRITIONAL COUNSELING (\$46.00)	FREQUENCY	BUNDLE FEE
Low risk	D0601	D1310	6 months	\$61.00
Moderate risk	D0602	D1310	4 months	\$61.00
High Risk	D0603	D1310	3 months	\$61.00

Silver Diamine Fluoride (SDF)

- » SDF as a statewide dental benefit in alignment with the national dental care standards
- » SDF is a covered service available for all ages
 - Subject to medical necessity
- » Procedure code D1354 Interim Caries Arresting Medicament Application per tooth
 - The criteria must be met for payment
 - Paid \$12.00 per tooth

CalAIM Benefit: D1354 Caries Arresting Medicament

- » D1354 is a benefit once every 180 days, up to ten teeth per visit, for a maximum of four treatments per tooth, and requires a tooth code.
- » For members <u>under age 7</u> a photograph is required
 - Flexibilities allowed for members under age 4 (per SB 1403)
- » Members age 7 or older:
 - Current intraoral photograph and
 - Current diagnostic periapical radiograph and
 - Must document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal

Continuity of Care: Pay for Performance (P4P)

- » This P4P payment offers a flat rate payment to dental provider service office locations that maintain dental continuity of care by:
 - Performing at least a yearly dental exam/evaluation for two or more years in a row
- » Paid at the flat rate of \$55 once per year in addition to the SMA
 - Payment included in the weekly check write
- » SNC claims will need to be validated for qualifying codes prior to issuing payment
 - Performance payments are earned and paid to SNC locations once a month

Continuity of Care: Example

Exam/evaluation paid for two or more consecutive years qualifies the service office location for a flat rate performance payment.

PAID EXAM/EVALUATION	CALENDAR YEAR 2022	CALENDAR YEAR 2023				
D0120, D0145, D0150	X	X				

Continuity of Care: Dental Codes

Service office locations are eligible to earn performance payments using any of the specified codes below:

- » On one service performed annually
- » At the flat rate of \$55

PROCEDURE CODE	PROCEDURE CODE NAME
D0120	Periodic Oral Evaluation – Establish Patient
D0145	Oral Evaluation For A Patient <u>Under</u> Three Years Of Age And Counseling With Primary Caregiver
D0150	Comprehensive Oral Evaluation – New Or Established Patient

Resources and Forms for CalAIM

- » DHCS-CalAIM website:
 - 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

Electronic Data Interchange

Electronic Data Interchange (EDI)

- » EDI is the way that claims are submitted to Medi-Cal Dental electronically
- » EDI claims are processed an average of five days faster than paper claims
- » Over 70% of Medi-Cal Dental incoming documents are received electronically
- » Claims, TARs, and NOAs can all be processed electronically

Benefits of Using EDI

- » Maximize computer capabilities
- » Make billing simpler
- » Have fewer rejections
- » Have tracking capabilities
- » Receive payment faster
- » Saves Money!

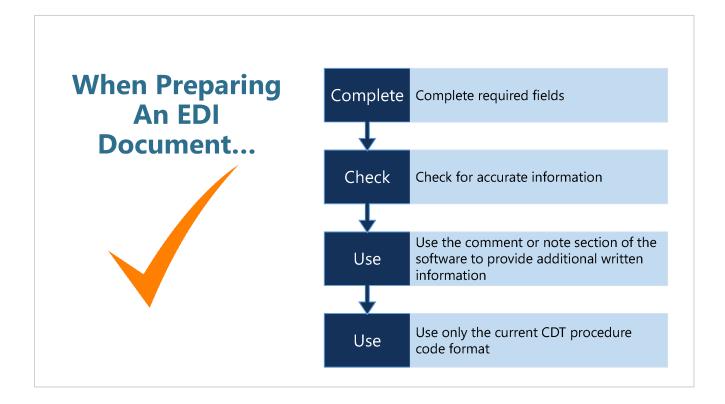
EDI Savings Calculator

- » From the website: www.ndedic.org
- » Click on the 'Resources' Tab and select the 'Calculator'
- » Enter your data
- » Click 'Calculate' to see your savings



Getting Started With EDI

- » Must have practice management software and access to the internet
 - The practice management software may require you to enroll with a clearinghouse which works with their system
- » Must enroll with the EDI department before submitting electronically
 - It takes 5-7 days for enrollment to process
 - Then you will be notified by phone and written correspondence
 - Read the EDI How to Guide!
- » Do not send electronically until the office has been notified of activation by Medi-Cal Dental



Clearinghouse Daily Reports

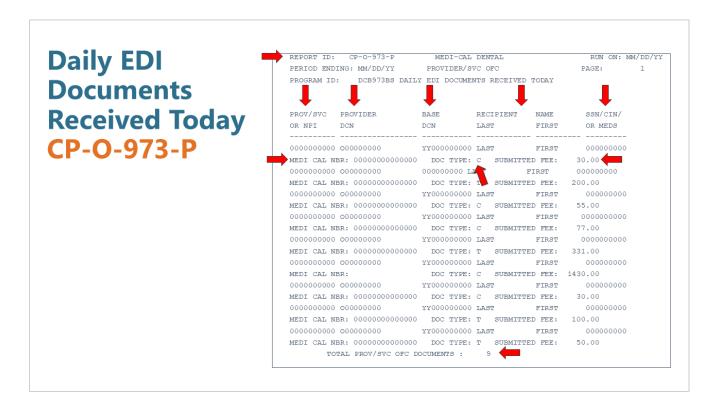
Submitter Report

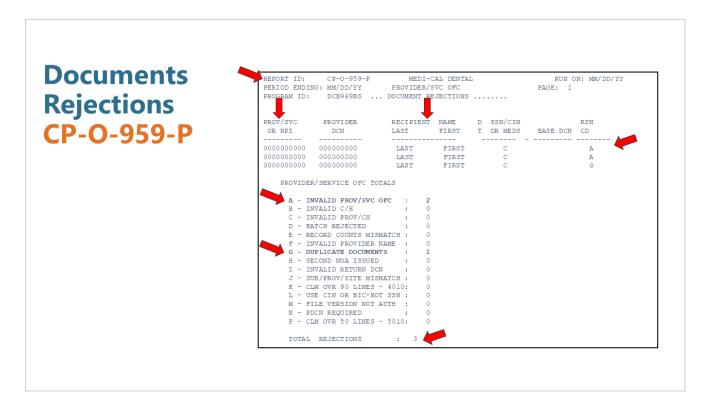
» This report is generated prior to the transmission of the claims to the clearinghouse

Transmission Summary Report

» This is verification that the claims have been received by the clearinghouse and have been submitted to the appropriate payers

Medi-Cal Dental EDI Reports





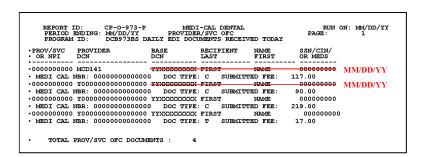
The Binder System

- » One way to manage the EDI reports is "The Binder System"
- » In a standard three ring binder:
 - Place index tabs numbered 1-31 (for the days of the month)
 - File the Transmission or CP-O-973-P report under the date billed from the office
- » This gives a starting point to track the EDI claims



The Binder System

- » Indicate the date each claim is processed on the CP-O-973-P report
- » Remove page once all claims are processed



Claims with Attachments

- » For offices submitting documents through the mail:
 - Use the Base DCN listed on the report ID: CP-O-971-P
 - Mail radiographs to Medi-Cal Dental using special red EDI labels and red-bordered envelopes
- » For offices enrolled with a digitized imaging company, follow the format and instructions provided on sending:
 - Digitized images of radiographs/photos
 - Justification of Need (DC-054) forms
 - And narrative reports to Medi-Cal Dental

Digitized Images

- » The digitized image number must be the 1st item in the comments/notes field
- » Don't forget to include the '#' sign

(NEA#999999/DTX#9999999/EHG#999999)

- » The date on the radiographs should match the "image created date"
 - The date the film/sensor was actually in the member's mouth

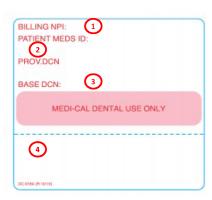
Digitized Images Not Successfully Submitted

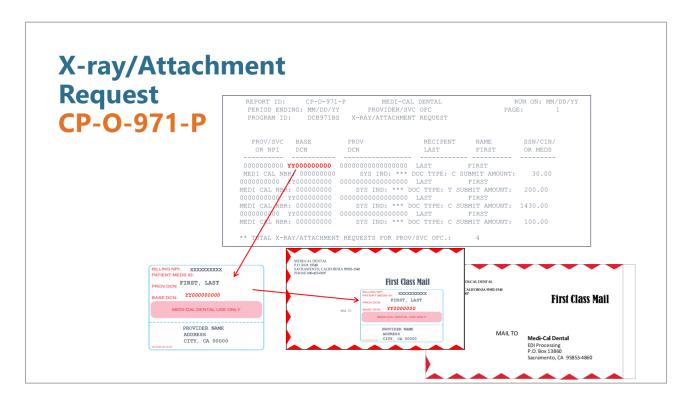
- » If radiographs or attachments are not successfully submitted using digitized imaging, the office will receive the X-Ray/Attachment Request Report, CP-O-971-P
- » It will then be necessary to submit radiographs and attachments using the label process

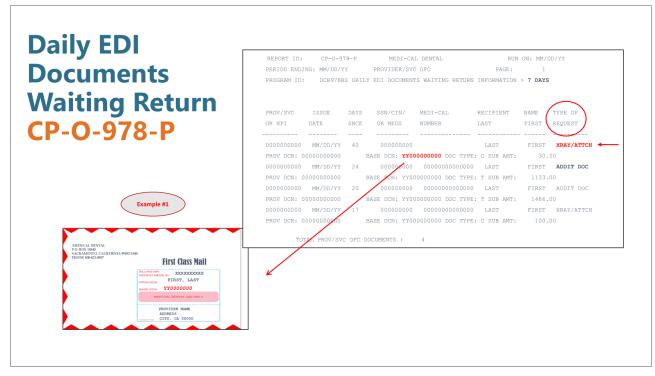
Red EDI Labels

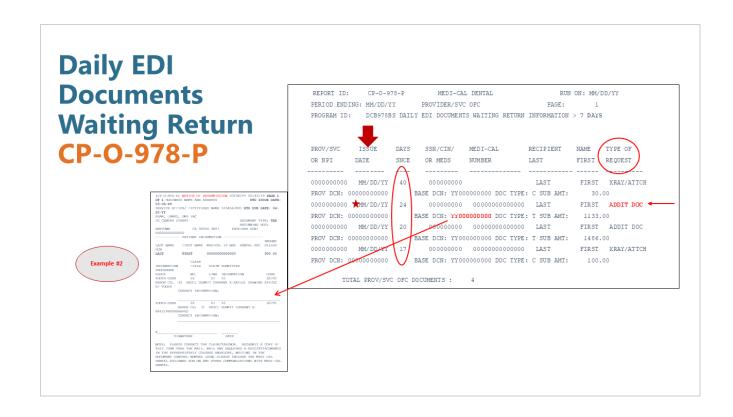
Labels must include:

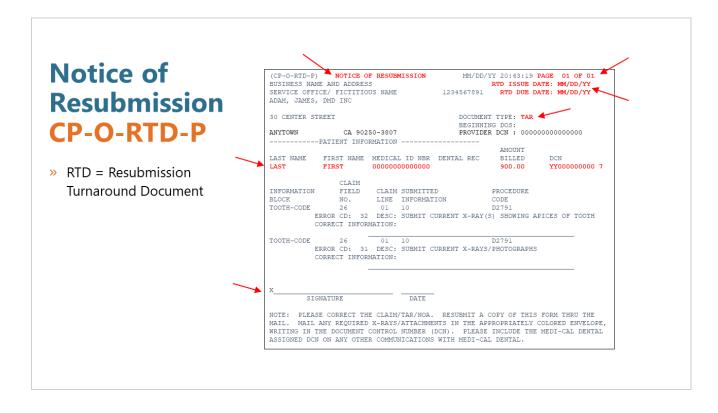
- 1. Billing NPI
- 2. Member's first and last name below "PATIENT MEDS ID"
- Base DCN
- 4. Provider's name and address

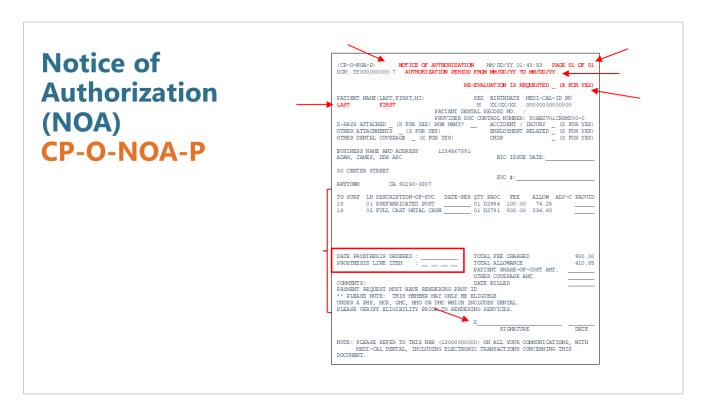


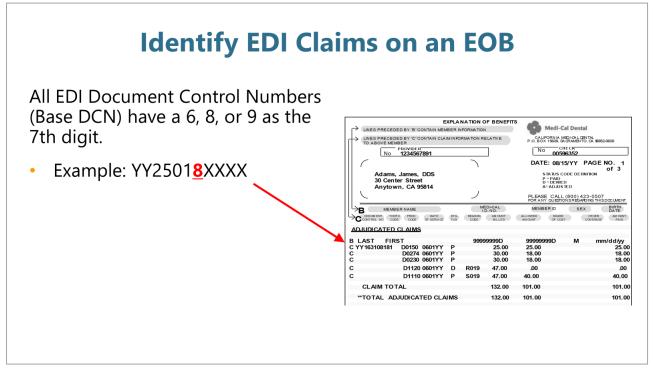












EDI Support

For additional EDI information and support please contact:

- 800-423-0507
- medi-caldentaledi@gainwelltechnologies.com

Claims Processing Flow Chart



Provider

 Enrolled providers send documents into Medi-Cal Dental



Mail Room

- Receive mail daily
- Documents are placed in bins tagged with the date of receipt
- Documents prepared for scanning
 - Ensuring envelopes are emptied
 - ✓ Fixing holes and tears
 - Removing paperclips, staples, etc.



Sorting

- Sort by document type
 - ✓ Claim, TAR, NOA, RTD. EDI, etc.
- Number of attachments
- Number of forms
- Radiographs or Photographs included
- Document is linked with their respective radiograph or photograph by using unique barcode
- Review for final quality check



Batching

- Documents are placed into bundles for scanning
- Type of form in bundle
- Type of batch (single, single with attachments, or multiple forms
- Receipt date
- Number of documents in the bundle
- Photographs or radiographs
- Create the Document control number (DCNs)
- And bar code of each batch document



Scanning

- Batch information verified
 - ✓ Batch Description
 - ✓ Priority
 - ✓ Receipt date
- Documents are scanned
- Scan ID imprints on each document (Scan DCN)
- Operator preforms an image quality verification



Data Coorection

- Captured data considered questionable by scanning system id passed to the Data Correction department.
- Data Correction department corrects information that the scanner could not read
- Operators correct inaccurate data



Adjudication

 Documents are processed by the system or manually processed depending on procedures, criteria, and document types



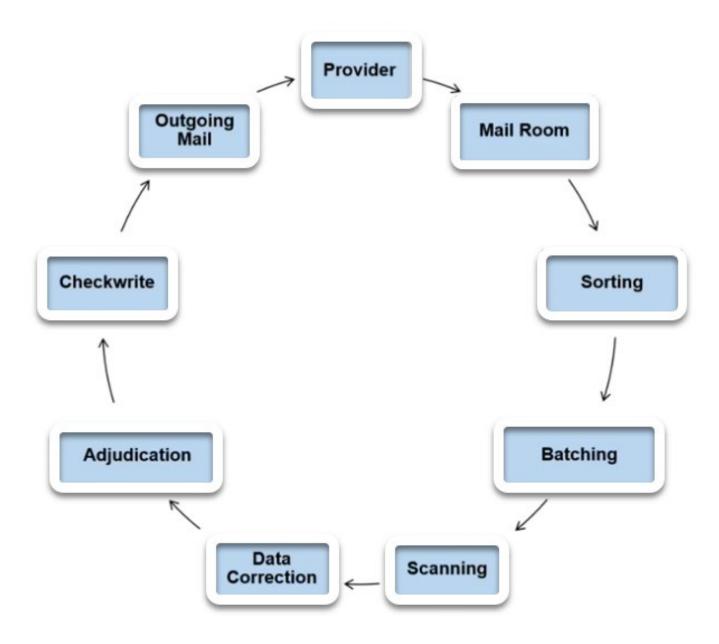
Check Write

 Checks are produced on a weekly basis for documents processed during previous week



Outgoing Mail

- Mail sent out daily: CIR, NOA, RTD's, EOBs, Outgoing Provider and member correspondence
- Checks are weekly



Provider Forms

Provider Forms: TAR/Claim, NOA, RTD, EOB

- » Use only these Medi-Cal Dental forms to bill or send prior authorization
- » All forms and envelopes are free of charge
 - Re-order through Medi-Cal Dental forms supplier
 - https://dental.dhcs.ca.gov/MCD_documents/providers/dc204_form.pdf
- » Best Practices:
 - Do Not: make copies, puncture holes, use whiteout, or use stamp signatures
 - Do: use only live signatures and make sure alignment is correct
 - Contact the Telephone Service Center 800-423-0507 for a reprint of a document.

In administering California Medi-Cal Dental, the primary function is to process Claims and Treatment Authorization Requests (TARs) submitted by providers for dental services performed for Medi-Cal members. It is the intent of Medi-Cal Dental to process documents as quickly and efficiently as possible.

Only Medi-Cal Dental specific, State-approved forms are accepted by Medi-Cal Dental. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Medi-Cal dental covered services. An introductory packet of billing forms is mailed to all newly enrolled providers so they may begin participating in Medi-Cal Dental. All billing forms are available from the Medi-Cal Dental forms supplier at no charge to providers.

The Provider Handbook Section 6 (Forms) contains detailed, step-by-step instructions for completing each of the Medi-Cal Dental forms. The handbook also provides a handy Do and Do Not list to help complete treatment forms accurately.

All incoming documents are received and sorted by Gainwell Technology. Claims and TARs are separated from other incoming documents and correspondence and then assigned a Document Control Number (DCN). The DCN is a unique 11-digit number that identifies the treatment form throughout the processing system. By using the DCN, Medi-Cal Dental can answer inquiries concerning the status of any treatment form received.

DCN = Document Control Number CRN = Correspondence Reference Number

YY	091	1	12345
Year	Julian Date	Document Identifier	Sequential Number

Document Identifier Code							
1. Claim/TAR	5. Written Correspondence						
2. RTD	6. Enrollment Forms						
3. CIF	7. Telephone Inquiry						
4. MC177	8. NOA						

The Treatment Authorization Request (TAR)/Claim Form

The TAR/Claim form is used to request authorization of proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Medi-Cal Dental. If there is more than one dentist or dental hygienist alternative practice (RDHAP) at a service office billing under a single dentist's provider number, enter the NPI of the dentist or RDHAP who performed the service.

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed. To submit the TAR/Claim form to Medi-Cal Dental, follow these steps:

- 1. Check the form for completeness. Sign and date the form where appropriate.
- 2. Use two separate forms when requesting payment for dated services and prior authorization of treatment for other services. This will expedite reimbursement of allowable procedures.
- 3. When using forms DC-202 or DC-209, detach page 2 "yellow page" and retain for the patient's record. If using form DC-217, print an additional laser copy for the patient's record.
- 4. If required, include necessary copies or duplicate radiographs/photos by stapling them to the corresponding form. More information may be found in Section 6: Forms, of the Handbook.
- 5. Mail the completed form(s) in the large pre-addressed mailing envelope (DC-206) that is provided to you free of charge. Up to 10 forms with attachments may be mailed in a single document mailing envelope.
- 6. Mail the TAR/Claim forms to:

Medi-Cal Dental
P.O. Box 15610
Sacramento, CA 95852-0610

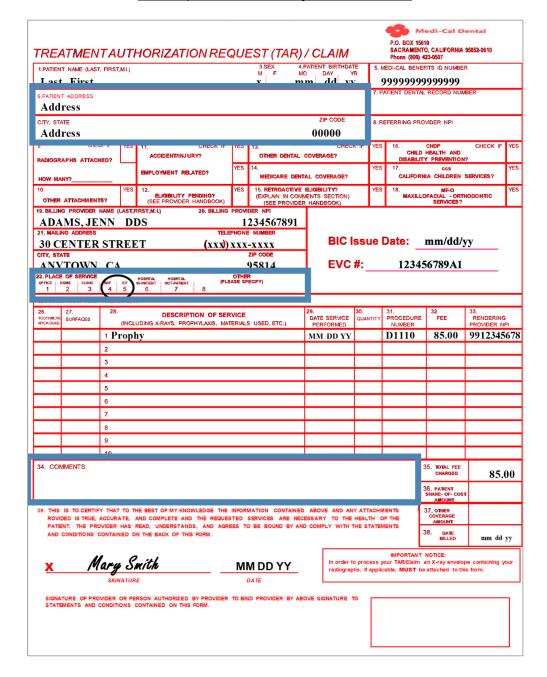
Treatment Authorization Request (TAR) Sample

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TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM P.B. BOX 15610 SACRAMENTO. CA 95852-9610 Phone (860) 423-9567													
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Address									L				
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Address			00000								_		
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HOW MANY?9		EMPLOYMENT RELATED?	YES	14. MED	ICARE DEN	TAL	COVERA	GE:	YE	B 17. CALIFO	CCS RNIA CHILDREN	SERVICES?	YES
10. OTHER ATTACHMENTS?	YES X	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	(EXPLAIN	OACTIVE E I IN COMME PROVIDER	NTS	SECTION	9	YE	18. MAXILL	MF-O OFACIAL - ORTH SERVICES?	ODONTIC	YES
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Signi	ATUR	E		DATE									
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Claim Form Sample

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			PERSON AUTHORIZED BY P		BING	DPRO	VIDER BY A	вον	VE SIGNATURE 1	го					
													D	C-217 (R 10/19))

Example of a Facility Claim Form



When the patient resides in a qualifying facility, the following information is required:

- Box 6: Member address = Facility's address
- Box 22: Check #4 or #5 regardless of where the member is being treated
- Box 34: Comment Box:
 - Facility name and phone number
 - If treating patients outside of the facility, indicate in box 34 where the patient is actually being treated, i.e., office, hospital

TAR/Claim Form Helpful Hints and Reminders

- 1. Use only the Current CDT procedure codes. Be sure to use all four digits including the leading "D".
- 2. Use the quantity column (Field 30) when listing multiple procedures with the same procedure number.
- 3. When submitting the form for payment of dated services, be sure to include the rendering provider number in Field 33.
- 4. Sign and date the form.
- 5. Staple any necessary attachments (e.g., operative reports, DC-054 Forms and/or copies of radiographs/photos, etc.) to the back of the form with one staple in the upper right or left corner.
- Continuous TAR/Claim forms and laser forms are not pre-imprinted by Medi-Cal Dental. Enter the provider's name, number, and address exactly as it appears on your initial stock of forms.
- 7. If dated services are submitted on a request for authorization, they will not be paid until the authorized services are paid.
- 8. Medi-Cal Dental's evaluation of TARs and Claims will be more accurate when narrative documentation is included. Use Field 34 for any narrative documentation.
 - a. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
 - Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form
 - c. If submitting electronically, abbreviate comments to make optimum use of allotted space.

Billing Limitations

The Medi-Cal Dental program will consider payment for dated services based on the Schedule of Maximum Allowance (SMA) if the form is received:

Payment % of SMA	Time Frame
100%	Within 6 months of the date of service
75%	Within 7 to 9 months of the date of service
50%	Within 10 to 12 months of the date of service
0	After 12 months from the date of service

[»] Payment is ALWAYS subject to member eligibility

Notice of Authorization (NOA) Form

The NOA is a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization. Medi-Cal Dental will indicate on the NOA whether the requested services are allowed, modified, or disallowed. Subsequently, the NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

The NOA will be pre-printed by Medi-Cal Dental with the following information:

- Authorization period (the 'From' and 'To' date)
- Member information
- Provider information
- Procedures allowed, modified, and/or disallowed
- Allowance
- Adjudication Reason Codes (A list of adjudication codes may be found in section 7 of the Provider Handbook)

NOTE: Prior to completing the form, verify the information printed is correct.

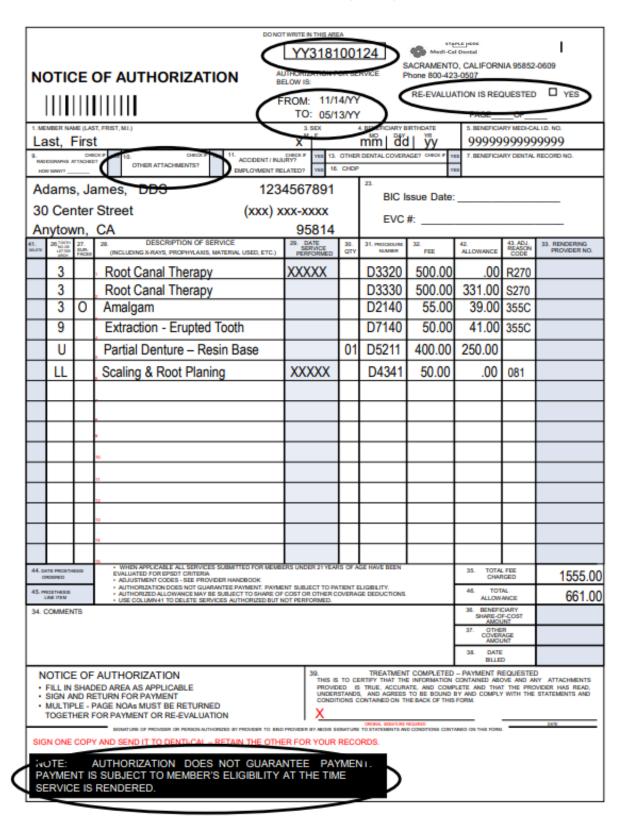
The NOA has a statement printed on the bottom of the form that reads: "NOTE: Authorization does not guarantee payment. Payment subject to member's eligibility." This statement has been added to remind providers to verify the member's eligibility prior to providing services.

- Prior to January 29, 2025, the service must be completed within the 180 days window as allowed on the Notice of Authorization (NOA).
- Approved NOAs and denied NOAs submitted for re-evaluations, processed on and after January 29, 2025, once approved, will be authorized for 12 months (365 days) to complete the treatment for all procedure codes.

Services not requiring prior authorization may be added to the NOA. However, any required radiographs and/or documentation for those procedures must be included.

Medi-Cal Dental will consider payment of 100% of the Schedule of Maximum Allowances (SMA), for services rendered if the NOA form is received within six months of the FINAL date of service. If the NOA is received within seven to nine months of the FINAL date of service, 75% of the SMA will be considered for payment. And, if the NOA is received within ten to twelve months of the FINAL date of service, 50% of the SMA will be considered for payment.

Notice of Authorization (NOA) Sample



NOA Reevaluation Request

Re-evaluation of a modified or denied treatment plan may be requested. The reevaluation request must be received by Medi-Cal Dental on or prior to the expiration date. To request reevaluation, follow these steps:

- 1. Check the box marked "RE-EVALUATION REQUESTED" in the upper right corner of the NOA.
- 2. Do not sign the NOA.
- 3. Include new or additional documentation and enclose radiographs, as necessary.
- 4. Return the NOA to:

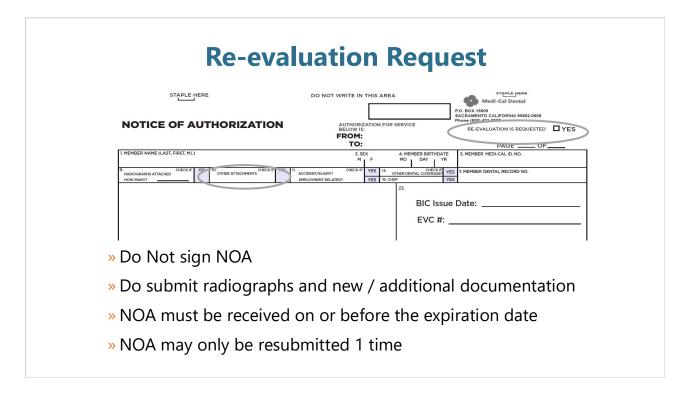
Medi-Cal Dental

P.O. Box 15609

Sacramento, CA 95852-0609

5. After reevaluation, a new NOA will be sent to your office.

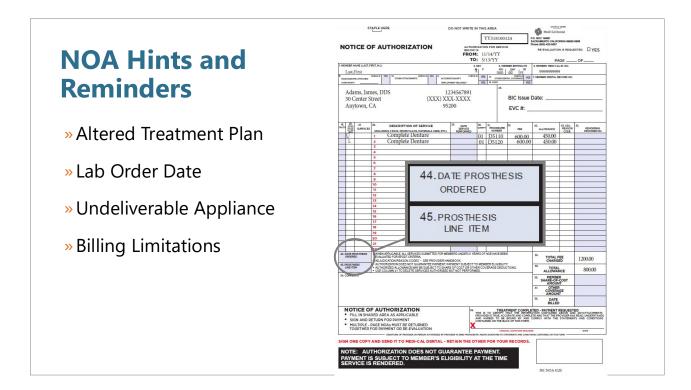
If a denial is upheld and another review is wanted, a new TAR must be submitted.



NOA Helpful Hints and Reminders

- 1. Providers must wait until the NOA is received from Medi-Cal Dental before providing services that require prior authorization.
- 2. Do not attach a CIF when requesting a reevaluation.
- 3. Return all upper pages of a multi-page NOA at the same time.
- 4. Include the rendering provider number in Field 33 of the NOA.
- 5. Sign and date the NOA when submitting for payment.

NOTE: Authorization does not guarantee payment. Payment is subject to a member's eligibility. Refer to the Provider Handbook Section 6 (Forms) for more information.



Resubmission Turnaround Document (RTD)

An RTD is a computer-generated form used by Medi-Cal Dental to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The RTD is divided into two sections: Section "A" and Section "B".

Section "A" notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section "A" is assigned a letter of the alphabet under "field." Section "A" is kept by the provider for office records. Section "A" also indicates the return due date. The provider has 45 days to respond to the RTD.

Section "B" is the corrected information filled in by the provider. This section is returned to Medi-Cal Dental.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

To ensure the RTD is properly processed, follow these steps:

- 1. Sign and date the RTD. If the RTD is returned unsigned, the requested information cannot be used to process the original claim, TAR or NOA.
- 2. Return all pages of a multi-page RTD in one envelope.
- Return the RTD promptly. If the RTD is not received by Medi-Cal Dental, within the 45-day time limitation, Medi-Cal Dental must deny the original claim, TAR or NOA.
- 4. Return the RTD to:

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

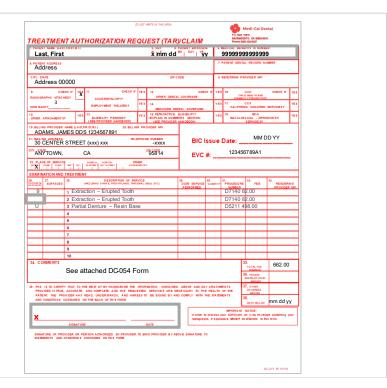
Upon receipt of the RTD, Medi-Cal Dental matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

NOTE: If the RTD is not returned within the 45-day time limitation, the TAR, Claim or NOA will be denied according to Medi-Cal Dental policies.

Refer to the Provider Handbook Section 6 (Forms) for more information.

» Example of why an RTD might be sent to your office:

- Mismatched member information
- Missing tooth code
- Missing live signature



Resubmission Turnaround Document Sample

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BILLING PROVIDER NAME Adams, James, DDS MEDI-CAL PROVIDER NUMBER 1234567899 PATIENT NAME Last, First PATIENT MEDICAL I.D. NUMBER 999999999 This is to certify that the corrected information is true, accurate and complete and that the provider have read understands, and agrees to be bound by and comply with the statements and conditions contained on the back of the form.	MEDI-CALI DCN YY297102350 SUBMITTED INFORMA	DENTAL USE CAMP TON 126	PROPER PAGES O1 oF O1 CAM EFFOR LINE COLE	CI CI	NTERED ON TI RROR SHOWN	

Explanation of Benefits (EOB)

The EOB is a computer-generated statement that accompanies each Medi-Cal Dental payment. It lists all paid, modified and denied claims which have been processed during the payment cycle, as well as adjusted claims, and claims and TARs which have remained "in process" for more than 18 days. The EOB also shows non-claims-specified information, such as payable/receivable amounts, and levy deductions. EOBs are normally issued weekly.

Following is an explanation of each item shown on the sample EOB:

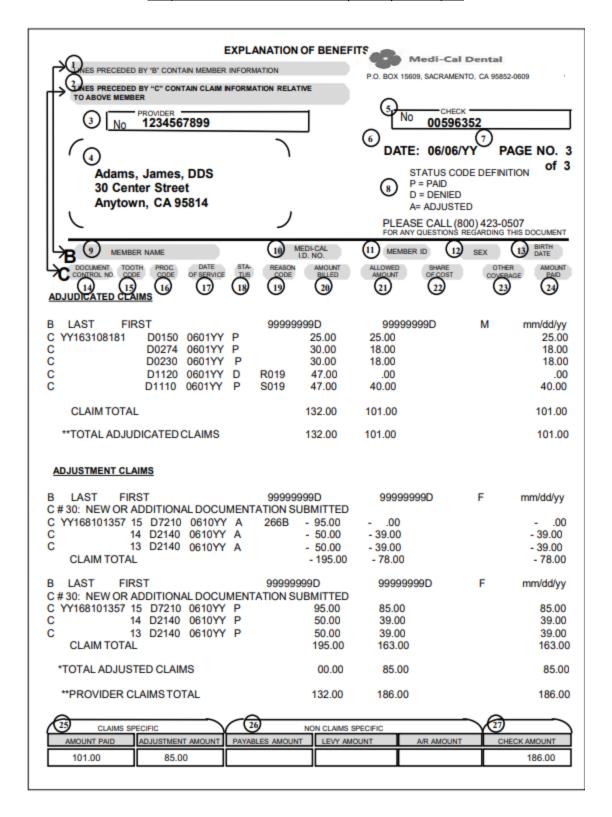
- 5. **Member information:** This line is preceded by an "B" for member information.
- Claim information for the listed member: This line is preceded by a "C" for "Claim".
- 7. **Provider Number:** The National Provider Identifier (NPI) number that was issued by NPPES to a provider for their type of business.
- 8. **Provider Name and Address:** The provider's name and billing address.
- 9. Check Number: The number of the check issued with the EOB.
- 10. Date: The date the EOB was issued.
- 11. Page Number: The page number(s) of the EOB.
- 12. **Status Code Definition:** The list of each status code used to identify a claim line and explanation of what each code means.
- 13. **Member Name:** The name of the member; last name, first name and middle initial. Each member is listed individually.
- 14. **Medi-Cal ID Number:** The number issued to the member by Medi-Cal and shown on the BIC (only the first nine digits will appear on the EOB).
- 15. **Member ID:** The member's ID number.
- 16. **Sex:** The sex of the member.
- 17. **Birth Date:** The member's date of birth.
- 18. **Document Control Number:** The identifying number assigned to each claim received by Medi-Cal Dental.
- 19. **Tooth Code:** The tooth number or letter, arch code or quadrant listed to help identify the procedure(s) reported on the EOB.
- 20. Procedure Code: The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.
- 21. Date of Service: The date the service was performed.

22. **Status:** Identifies the status of each claim line. (See item 8 for a list of status codes and their definitions.)

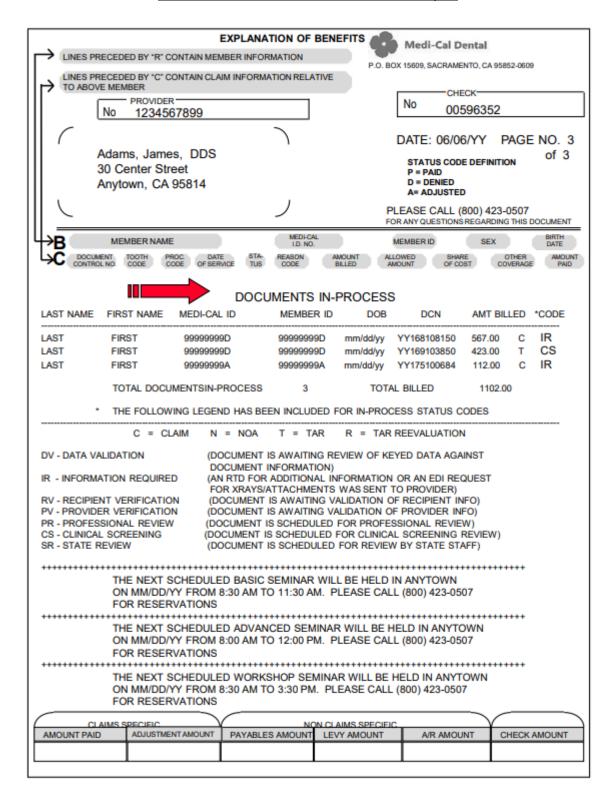
- 23. Reason Code: Explains why a claim line was either denied, modified, altered, or paid at an amount other than billed. The reason codes and a written explanation of each one are printed on the EOB.
- 24. Amount Billed: The amount billed for each claim line.
- 25. **Allowed Amount:** The amount allowed by Medi-Cal Dental for each claim line. This amount is the lesser of the billed amount and maximum amount allowed by the Schedule of Maximum Allowances (SMA).
- 26. Share of Cost: The amount the member paid toward a Share of Cost.
- 27. Other Coverage: The amount paid by Medicare or any other insurance carrier.
- 28. **Amount Paid:** The total amount paid to a provider after any applicable deductions shown in item 22 and 23.
- 29. Claims Specific: The total amounts of all paid and adjusted claims listed on the EOB.
- 30. **Non-Claims Specific:** The total payable amounts, levy amounts, and receivable amounts listed on the EOB, if applicable. This information is printed on the last page of the EOB.
- 31. Check Amount: The amount of the check that accompanies the EOB.

Refer to the Provider Handbook Section 6 (Forms) for more information.

Explanation of Benefits (EOB) Sample



EOB Documents in Process Sample



Claim Inquiry Forms (CIF)

Submitting a Claim Inquiry Form (CIF) enables Medi-Cal Dental to give an automated, fast response to an inquiry. The dental office should use the CIF for two reasons:

- 1. Inquire about the status of a TAR or Claim
 - a. Medi-Cal Dental will respond to a CIF with a Claim Inquiry Response (CIR).
- 2. Request reevaluation of a modified or denied claim or NOA for payment.

CIF Tracer

A CIF tracer is used to request the status of a TAR or claim. Providers should wait one month before submitting a CIF Tracer to allow enough time for the document to be processed. If after one month, the claim or TAR has not been processed or has not appeared in the "Documents In-Process" section of the Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Reevaluation

A CIF claim re-evaluation is used to request the reevaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the "Adjusted Claims" section.

Claim re-evaluations must be received within 6 months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

To submit a CIF to Medi-Cal Dental, follow these steps:

- 1. Use a separate CIF for each inquiry.
- Check only one inquiry reason box on each CIF.
- 3. Complete all applicable areas.
- Sign and date.
- 5. Attach all related radiographs/photos.
- 6. Do not use the CIF to request a first level appeal.

7. Mail to:

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

Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Telephone Service Center at (800) 423-0507

All radiographs/photos submitted with a CIF must be stapled to the back of the corresponding CIF.

Refer to the Provider Handbook Section 6 (Forms) for more information.

Claim Inquiry Response (CIR)

Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Medi-Cal Dental will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- Member name
- Member Medi-Cal identification number
- Member Dental Record or account number, if applicable
- Document Control Number of the original document
- The date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY" will contain a status code and a typed explanation of that code. Refer to the Provider Handbook Section 7 (Codes) for more information.

Claim Inquiry Form - Tracer Sample

	IMPORTAN Before submitting a CIF: Allow one month for the status of the document of Benefits (EOB) Type or print all information Use the appropriate X-ray envelope and att See your Provider Handbook for detailed in For clarification call the Medi-Cal Dental	ment to appear on your ach to this form)	CLAIM INQUIRY FORM Medi-Cal Dental P.D. BOX 16609 SACRAMENTO, CALIFORNIA 96862-0808 Phone (800) 428-0607
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Claim Inquiry Form - Reevaluation Sample

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Claim Inquiry Response Sample

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es. DDS				
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The Provider Appeals Process

First Level Appeals

- » Submit appeal within 90 days:
 - Use letterhead not a CIF
 - Letter must specifically request a 1st Level Appeal
 - Send all information/copies to uphold the request
 - Send Appeals directly to the Appeals address
 - Office will receive written notification from Medi-Cal Dental within 21 days

Address: Medi-Cal Dental

Attn: Provider First-Level Appeals

PO Box 13898

Sacramento, CA 95853-4898

» Last recourse with Medi-Cal Dental

First Level Appeals

A provider may request a First Level Appeal by submitting a formal written grievance to Medi-Cal Dental. Submission of a CIF is not required prior to the First Level Appeal.

The First Level Appeal procedure is as follows:

- 1. The provider must submit the appeal by letter to Medi-Cal Dental within 90 days of the EOB denial date. Do not use CIFs for this purpose.
- 2. The letter must specifically request a first-level appeal.
- Send all information and copies to justify the request. Include all documentation and radiographs.
- 4. The appeal should clearly identify the claim or TAR involved and describe the disputed action.
- 5. First-level appeals should be directed to:

Medi-Cal Dental

Attn: Provider First-Level Appeals

PO Box 13898

Sacramento, CA 95853-4898

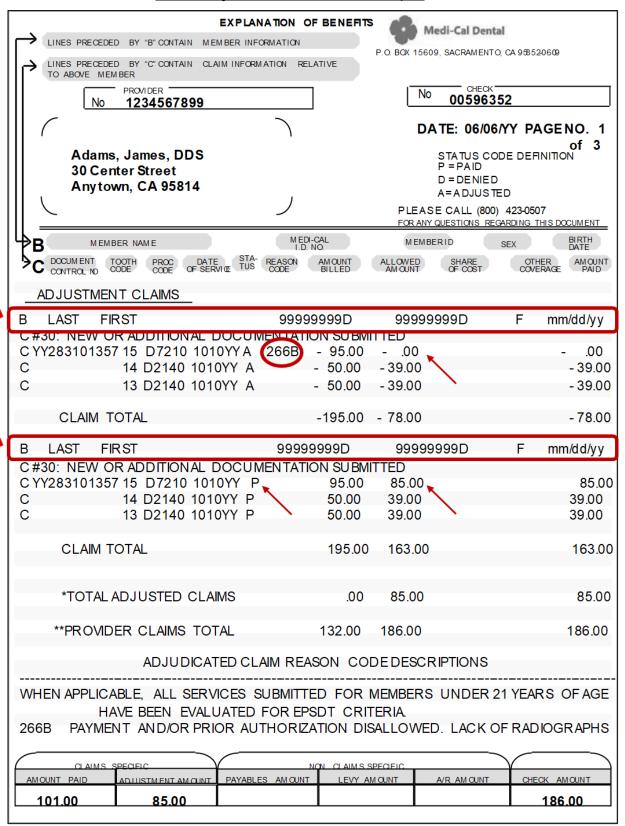
The Medi-Cal Dental staff (including professional review if necessary) will review the appeal and respond in writing if the denial is upheld.

The provider should keep copies of all documents related to the first-level appeal.

Judicial Remedy

Under Title 22 regulations, a Medi-Cal Dental provider who is dissatisfied with the first-level appeal decision may then use the judicial process to resolve the complaint. In compliance with Section 14104.5 of the Welfare and Institutions Code, the provider must "seek judicial remedy" no later than one year after receiving notice of the decision of the First Level Appeal.

EOB Adjustment Claims Sample



Glossary

Billing Provider: The dentist who bills or requests authorization for services on the treatment form.

Treatment Authorization Request (TAR)/Claim: The State approved universal form used by the provider to request prior authorization of services, and/or the form submitted by the provider to request payment for services performed.

Claim Inquiry Form (CIF): The form used by the provider for tracing a claim or TAR, or for requesting a reevaluation or adjustment to a previously submitted claim.

Explanation of Benefit (EOB): The Explanation of Benefits (EOB) is a computer-generated statement that accompanies each check sent to Medi-Cal dental providers. It lists all paid and denied claims that have been adjudicated or adjusted during the payment cycle, as well as non-claims specific information. Claims and TARs that have been in process over 18 days are also listed.

Correspondence Reference Number (CRN): An identifying number assigned to all telephone correspondence, written correspondence and CIF's received by Medi Cal Dental

Medi-Cal Dental: The Fee-for-Service portion of California Medi-Cal Dental.

Medi-Cal Dental Bulletin: A publication with information regarding Meid-Cal Dental updates, pertinent legislative action, procedure clarifications, and other important items which affect California Medi-Cal Dental. The bulletins may be accessed from the Medi-Cal Dental website.

Medi-Cal Dental Provider Handbook: A reference guide for all providers enrolled in Medi-Cal Dental. It contains the criteria for dental services, benefits, exclusions, limitations, and instructions for completing forms used in Medi-Cal Dental. The Handbook may be accessed from the Medi-Cal Dental website.

Document Control Number (DCN): An identifying number assigned to all billing documents received by Medi Cal Dental. The DCN enables Medi-Cal Dental to track the document throughout the automated processing system.

Notice Of Authorization (NOA): A computer-generated form sent to the provider following final processing of a TAR by Medi-Cal Dental. When the NOA is returned to Medi-Cal Dental by the provider, it becomes a claim submitted for payment of services rendered.

Provider: Individual dentists, dental group, dental school, or dental clinic.

Resubmission Turnaround Document (RTD): A computer-generated form which Medi-Cal Dental sends to the provider to request missing or additional information needed to complete processing of a claim, TAR or NOA.

Rendering Provider: The dentist who provides services that are billed under the billing provider's name and billing provider number. The rendering provider may be the same as, or different from the billing provider.