Provider Bulletin

SEPTEMBER 2019
Volume 35, Number 29

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TRAINING SEMINARS

To reserve a spot online or to view a complete list of training seminars, to go the Provider Training Seminar Schedule.

PROVIDER ENROLLMENT ASSISTANCE LINE

Speak with an Enrollment Specialist. Go here for more information.

Available every Wednesday 8am - 4pm

Medi-Cal Dental to Implement Current Dental Terminology 2019

The Medi-Cal Dental Program has been working diligently to update the Program's American Dental Association's Current Dental Terminology code set from Current Dental Terminology 2013 (CDT-13) to CDT-19. This update is scheduled to implement in the spring of 2020 and more information will be provided as the release date draws closer.

Important: Do Not Write on Checks

Medi-Cal Dental requests that providers not write on the face of checks issued by Bank of America. Anything handwritten on the face of a check is flagged as a fraudulent alteration of the check and sent to the issuer for further review. If a check has been written on, it will be returned unpaid and payment will be delayed. Examples of handwritten alterations to the front of a check include added phone numbers, names/name corrections, and/or stamps.

If providers have questions about their checks or need related assistance, please contact the Telephone Service Center at (800) 423-0507.

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County Children's Health Initiative Program Transition to Medi-Cal Dental

Effective October 1, 2019, the delivery of dental benefits for the County Children's Health Initiative Program (CCHIP), also known as Healthy Kids, operating in the counties of Santa Clara, San Mateo, and San Francisco will transition from their local dental plan to Medi-Cal Dental. To treat these children, providers must be enrolled in the Medi-Cal Dental Program and must confirm the children are transitioned to the Medi-Cal dental by viewing their eligibility status. Providers can verify eligibility through the Medi-Cal website or the Automated Eligibility Verification System (AEVS). For more information on member eligibility, please refer to the Dental Provider Handbook, Section 4 - Treating Beneficiaries, pages 4-3 through 4-5. Once these children are transitioned into the Medi-Cal program, dental providers must bill the Medi-Cal program for dental services according to the criteria outlined in the Dental Provider Handbook, Section 5 - Manual of Criteria and Schedule of Maximum Allowances.

Before CCHIP (Healthy Kids) are transitioned they will receive a:

- 60–day notice
- 30–day notice
- Medi-Cal Welcome Packet
- Benefits Identification Card

Don't miss out on serving these children by ensuring you are on the Patient Referral List! Sign up by clicking here, complete the form and send it in. If you have any questions about the Medi-Cal Dental Program, please call the Telephone Service Center at (800) 423-0507.

Clarification of Policy for Registered Dental Hygienists in Alternative Practice

The Medi-Cal Dental Program permits teledentistry as an alternative modality for the provision of select dental services. Billing providers enrolled in the Medi-Cal Dental Program may submit documents for services rendered utilizing teledentistry. Registered Dental Hygienists in Alternative Practice (RDHAPs) may also render services as part of teledentistry as long as such services are within their scope of practice and are rendered under the general supervision of a licensed dentist.

The following Current Dental Terminology (CDT) codes includes codes that RDHAPs may bill as part of teledentistry:

- **D0210:** Intraoral — complete series of radiographic images
- **D0220:** Intraoral — periapical first radiographic image

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- **D0230:** Intraoral — periapical each additional radiographic image
- **D0240:** Intraoral — occlusal radiographic image
- **D0270:** Bitewing — single radiographic image
- **D0272:** Bitewings — two radiographic images
- **D0274:** Bitewings — four radiographic images
- **D0350:** Oral/Facial photographic images

For dental services, documentation should be consistent with the standards set forth in the Manual of Criteria and all state laws. Per Welfare and Institutions Code, Section 14124.1, the required documentation for services rendered shall be retained in the patient medical record(s) for auditing and review purposes for a period of ten years from the date the service was rendered. Additionally, all claims must identify the rendering, ordering, referring, and prescribing provider as applicable.

For more information about teledentistry under the Medi-Cal Dental Program, please review Provider Handbook Section 4 - Treating Beneficiaries, page 4-14. For questions, please contact the Telephone Service Center at (800) 423-0507.

Outdated Versions of Treatment Authorization Request (TAR)/Claim Forms No Longer Accepted

Medi-Cal Dental is decommissioning outdated versions of the Treatment Authorization Request (TAR)/Claim form. **Effective January 30, 2020**, providers must use a current version of the TAR/Claim form when submitting to Medi-Cal Dental. The current TAR/Claim form numbers and revision dates are:

- DC-202 (R 08/13) - for filling in by hand
- DC-209 (R 07/13) - for pin-fed printers
- DC-217 (R 9/13) - for laser printers

Providers can confirm that they are using the most current version by checking the revision date at the bottom of the form. If a provider has outdated TAR/Claim forms in their dental office, please recycle the old forms and reorder new ones.

To order current TAR/Claim forms, please complete and send the Forms Reorder Request form to Medi-Cal Dental. Providers can find the Forms Reorder Request form on the Medi-Cal Dental website here.

For information on how to complete the TAR/Claim form, please refer to the Dental Provider Handbook, Section 6 - Forms, pages 6-6 and 6-7. For questions about the TAR/Claim form decommissioning effort, please contact the Telephone Service Center at (800) 423-0507.

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Justification of Need for Prosthesis (DC054) Form Update and How to Submit a Properly Completed DC054

Using the DC054 Form

Providers are required to submit a Justification of Need for Prosthesis Form (DC054) when submitting a Treatment Authorization Request (TAR) for complete dentures, immediate dentures (when immediate dentures are rendered in conjunction with an opposing complete denture or partial removable prosthesis), resin base partial dentures, cast metal framework partial dentures, and complete overdentures (procedures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, and D5860). The DC054 provides complete and detailed information necessary for screening and processing prosthetic cases. The form should include specific information about the member's oral condition **and** the condition of any existing prosthetic appliances.

PLEASE NOTE: An updated version of the DC054 form has been implemented. Providers are required to use the most current version (revision date 09/18). To order the most current DC054 form, please complete and send the Forms Reorder Request form to Medi-Cal Dental. Providers can find the Forms Reorder Request form on the Medi-Cal Dental website here.

Failure to submit a DC054 form will cause a delay in processing your request. If the information on the DC054 form is incomplete or contradictory, the requested prosthetic appliance(s) will be denied with Adjudication Code 155 (procedure requires a properly completed prosthetic DC054 form).

If you are enrolled to submit electronically through Electronic Data Interchange (EDI), providers also have the option to submit the DC054 form as an electronic attachment with a TAR. A sample of the DC054 form is on the following page.

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SAMPLE DC054

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.

1 PATIENT: ______________________________ 2 DATE: ______________________________

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

MAXILLARY ARCH	MANDIBULAR ARCH
3 Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Never had a maxillary prosthetic appliance	☐ Never had a mandibular prosthetic appliance
☐ Has an existing maxillary prosthetic appliance	☐ Has an existing mandibular prosthetic appliance
4 Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Existing Appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
Age of Appliance: ______________	Age of Appliance: ______________
Wears appliance? ☐ Yes ☐ No	Wears appliance? ☐ Yes ☐ No
If "No", please explain: ______________	If "No", please explain: ______________
Catastrophic Loss? ☐ Yes ☐ No	Catastrophic Loss? ☐ Yes ☐ No
Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.	Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.
If lost in facility or hospital, explain circumstances: ______________	If lost in facility or hospital, explain circumstances: ______________
5 Reason for replacement of existing maxillary appliance: (Check all boxes that apply)	Reason for replacement of existing mandibular appliance: (Check all boxes that apply)
☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework	☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework
☐ Extraction of additional teeth ☐ Other ______________	☐ Extraction of additional teeth ☐ Other ______________

Edentulous ☐ Maxillary ☐ Mandibular

6

X Block out missing teeth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
O 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)

7 MAXILLARY ARCH	MANDIBULAR ARCH
Teeth being replaced: ______________	Teeth being replaced: ______________
Teeth being clasped: ______________	Teeth being clasped: ______________

8 ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:
____
____
____
____
____
____

9 Provider Signature ______________________________

DC054 (Rev 09/18) ← **Current Version (09/18)**

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How to Complete the DC054 Form

The following is a sample DC054 form with instructions on how to correctly complete the document.

1. **PATIENT NAME:** Enter the member's name exactly as it appears on the Medi-Cal Benefits Identification Card (BIC).
2. **DATE:** Enter the date the member was evaluated.
3. **APPLIANCE REQUESTED:** Enter the type of prosthetic appliance requested on the TAR.
4. **EXISTING APPLIANCE:** Enter the type of prosthetic appliance that the member has or had (regardless of the condition of the appliance or whether the appliance has been lost, stolen or discarded). If the member has never had any type of prosthetic appliance, check the corresponding box.

Indicate whether the member wears the existing appliance and the age of the appliance that the member has (or had). If the appliance is no longer present due to a catastrophic loss (fire, earthquake, theft, etc.), attach the official public service agency report. If the prosthetic appliance has been lost in a certified facility or hospital, document the date of the incident and the circumstances of the loss. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details of the loss.

5. **REASON FOR REPLACEMENT OF EXISTING APPLIANCE:** Document the reason the existing appliance needs to be replaced. Check the boxes that apply. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details.

Reminder: When requesting a prosthetic appliance for only one arch, the opposing arch must also be evaluated and addressed as a comprehensive treatment plan.

6. **MISSING TEETH:** Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
7. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL:** Indicate the teeth being replaced by the requested appliance and the teeth being clasped.

Reminder: Please submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.

8. **ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:** Use this section for additional comments/documentation specific to the requested treatment. Some examples include:
    a. **NATURAL TEETH BEING RETAINED:** If teeth are being retained in the arch(es), indicate the treatment plan for the remaining teeth (root canals, periodontal treatment, restorative, crowns, etc.).
    b. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the member, indicate whether the member wants the proposed services.
    c. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the member to wear a prosthetic appliance. Document if the condition is temporary or permanent.
    d. **CONVALESCENT CARE:** If the member resides in a convalescent facility, document

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facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment. The TAR should include the facility name, address, and phone number.

9. **SIGNATURE:** The dentist completing the form must sign the form.

If you have any questions, please contact the Telephone Service Center at (800) 423-0507.

Go Green! Submit Documents Electronically through Electronic Data Interchange

Looking for a way to reduce your carbon footprint? Go paperless with Electronic Data Interchange (EDI). EDI submissions make billing and tracking documents easier and helps maximize practice management system capabilities. You can enroll to participate by visiting this link: EDI program.

Enroll in the EDI program to submit Claims and Treatment Authorization Requests (TARs), Notices of Authorization (NOAs), and Claim Adjustments electronically. As an EDI-enrolled provider, you can also receive NOAs, Resubmission Turnaround Documents (RTDs) and Explanation of Benefits (EOB) data electronically.

Medi-Cal Dental receives more than 65% of documents electronically. You can determine your own potential **cost savings** in submitting claims electronically by using the EDI savings calculator available on the National Dental EDI Council website.

Along with EDI documents, Medi-Cal Dental also accepts digitized radiographs and attachments submitted through the following electronic attachment vendors: Change Healthcare, DentalXChange, National Electronic Attachment, Inc. (NEA), National Information Services (NIS), and Tesia-PCI, LLC.

Additional information can be found in the EDI How-To Guide.

For information on how to enroll in EDI, please contact the Telephone Service Center at (800) 423-0507, or call (916) 853-7373 and ask for EDI Support. EDI-related questions can also be emailed to denti-calEDI@delta.org.

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2019 Medi-Cal Dental Payment Schedule Changes

The Medi-Cal Dental payment schedule changes are in observance of holidays. The table below provides the remaining 2019 holiday payment schedule.

2019 Medi-Cal Dental Payment Schedule Changes		
Holiday Adjusted For	Week Of	Payment Issue Date
Labor Day	September 2, 2019	September 6, 2019
Columbus Day	October 14, 2019	October 18, 2019
Veterans Day	November 11, 2019	November 15, 2019
Thanksgiving Holiday	November 25, 2019	November 29, 2019
Christmas Holiday	December 23, 2019	December 27, 2019
New Year's Day	December 30, 2019	January 3, 2020