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MEDI-CAL HAS DENTAL COVERED

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THIS ISSUE

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

Clarification of Procedure D9920

Behavior Management, By Report

This is a reminder from the Department of Health Care Services (DHCS) to providers when submitting a claim for procedure D9920, to include the medical diagnosis. The documentation must include the reason this medical diagnosis required the provider to spend extra time during the visit. Providers should indicate the reason(s) they are unable to render the procedure(s) to the patient within a reasonable amount of time. D9920 is intended for situations that require extra time due to a particular medical condition and is not intended for extra minutes to calm a patient down or to review an extensive medical history. D9920 shall not be paid to providers if the behavior modification modality is sedation. If this documentation is not provided, the claim may be denied.

DHCS recently noted a high volume of D9920 rejections. Approximately 25 percent of the denials had Adjudication Reason Code (ARC) 071C applied. ARC 071C states "Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit." In these cases, although the provider indicated a medical diagnosis, the provider did not adequately describe the behaviors that could be attributed to the patient's medical diagnosis which therefore resulted in additional time

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spent with the patient during the appointment. Pattern documentation should be avoided; documentation of extra time needed must be specific to an individual patient at a specific dental visit. (e.g., a special needs patient may not require additional time for a routine dental exam but the provider may require additional time to render restorative services).

As a reminder, procedure D9920 and its related ARCs can be reviewed below:

PROCEDURE D9920 – BEHAVIOR MANAGEMENT, BY REPORT

1. Written documentation for payment shall include documentation that the patient is a special needs patient that requires additional time for a dental visit. Special needs patients are defined as those patients who have a physical, behavioral, developmental or emotional condition that prohibits them from adequately responding to a provider's attempts to perform a dental visit. Documentation shall include the patient's medical diagnosis of such a condition and the reason for the need of additional time for a dental visit.

2. A benefit:

    a. For four visits in a 12 month period to compensate the provider for additional time needed for providing services to special needs patients.
    b. Only in conjunction with procedures that are payable.

ARC 071A: Behavior Modification (D9920) is not payable when sedation is used as a behavior modification modality.

ARC 071B: Behavior Modification (D9920) is only payable when the patient is a special needs patient that requires additional time for a dental visit.

ARC 071C: Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit.

Procedure D9920 was first updated in Provider Bulletin Volume 34, Number 21 and new ARCs for D9920 were announced in Provider Bulletin Volume 35, Number 14. For further questions about procedure D9920, please contact the Telephone Service Center at (800) 423-0507.

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CDT-19 Update: Dental Transformation Initiative Domain 1 Codes

As announced in Provider Bulletin Volume 36, Number 3, the Medi-Cal Dental Program is updating its Current Dental Terminology (CDT) code set from CDT-13 to CDT-19 and has published a new draft CDT-19 MOC and SMA. As part of the CDT-19 implementation, there are some impacts to Dental Transformation Initiative (DTI) Domain 1 procedure codes. These impacts are listed in the table below.

DTI Domain 1 CDT-19 Impacts				
Procedure Code	Procedure Code Description	Benefit Prior to CDT-19 Implementation	Benefit After CDT-19 Implementation	Effective/ End Date
D1515	Space maintainer-fixed – bilateral	Yes	Deleted	March 14, 2020
D1516	Space maintainer - fixed – bilateral, maxillary	N/A	Yes	March 14, 2020
D1517	Space maintainer - fixed – bilateral, mandibular	N/A	Yes	March 14, 2020
D1520	Space maintainer-removable – unilateral	Yes	No	March 14, 2020
D1525	Space maintainer-removable – bilateral	Yes	Deleted	March 14, 2020
D1526	Space maintainer - removable – bilateral, maxillary	N/A	Yes	March 14, 2020
D1527	Space maintainer - removable – bilateral, mandibular	N/A	Yes	March 14, 2020
D1575	Distal shoe space maintainer-fixed- unilateral	No	Yes	May 16, 2020

To view the draft CDT-19 MOC and SMA, you can also visit the What's New section on the Medi-Cal Dental website. For more information about DTI Domain 1, visit the Department of Health Care Services website here.

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Enhanced Protections for Medi-Cal Members

Providers may not submit a claim to, or collect reimbursement from, a Medi-Cal member or an authorized representative, except for the specified share of cost a member's eligibility status requires for any service. Title 22, California Code of Regulations, Section 51002 (a) and Welfare and Institutions Code (WIC) Section 14019.4 (a) expressly prohibits a provider from billing a Medi-Cal member for services included in the Medi-Cal Dental Program scope of benefits. Furthermore, a provider may not bill both the member and the Medi-Cal Dental Program for the same dental procedure.

A new law, Senate Bill 639, effective July 1, 2020, specifies in Business and Professions (B&P) Code, if a dental provider accepts Medi-Cal, the treatment plan for a Medi-Cal patient shall indicate if Medi-Cal would cover an alternate, medically necessary service as defined in current law, WIC Section 14059.5. The treatment plan shall indicate that the Medi-Cal patient has a right to ask for only services covered by Medi-Cal and that the dental provider agrees to follow Medi-Cal rules to secure Medi-Cal covered services before treatment.

Current Law:

- Dentists shall not arrange for or establish third-party credit or loans for patients administered or under the influence of general anesthesia, conscious sedation, or nitrous oxide. [B&P Code § 654.3(g)].
- Dentists shall not charge to third-party lines of credit (arranged for or established in their office) any treatment costs before the treatments are provided, unless the dentist provides the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs. [B&P Code § 654.3(b)].
    - The written treatment plan must include:
        - Each anticipated service to be provided and the estimated cost of each service;
        - The patient's private or government-estimated share of cost for each service (if applicable, including whether Medi-Cal will cover the service); and
        - If services are not covered by patient's private or other insurance (including Medi-Cal), notification that the services may not be covered and that the patient has the right to confirm coverage before starting dental treatment.
    - Written notice must be provided in patient's threshold language. [B&P Code § 654.3(f)].

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Changes effective July 1, 2020:

- All of the current requirements above continue to apply, with the following additions:
- Dentists shall not charge to third-party lines of credit (arranged for or established in their office) any treatment costs more than 30 days before the treatments are rendered (except for orthodontia). [B&P Code § 654.3(c)]
- Dentists shall not arrange for or establish an open-end credit or loan that contains a deferred interest provision (which is common under many current third-party credit companies). [B&P Code § 654.3(b)]
- Dentists shall not complete any part of a third-party credit or loan application (arranged for or established in their office) so that any application is not completely filled out by the patient. [B&P Code § 654.3(e)].
- Dentists shall provide the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs.
    - The notice must include the revised language specified in B&P Code § 654.3(g).
    - For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment. [B&P Code § 654.3(h)(1)].
- Dentists shall not arrange for or establish third-party credit or loans when patients are in a treatment area (including but not limited to exam rooms, surgical rooms, and any other area where dental treatment is provided) unless the patient agrees to do so. [B&P Code § 654.3(j)].

Providers can review Senate Bill 639 in its entirety here. For more information about Medi-Cal Dental billing practices, see Provider Bulletin Volume 35, Number 14 or refer to the Provider Handbook.