

**NOTICE OF MEDI-CAL DENTAL ACTION
THIS IS NOT A BILL**

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SERVICE OFFICE NAME :

MEDS ID :
DCN :
MRDCN :

PAGE OF
DATE OF REQUEST :
MEMBER NAME :

Medi-Cal Dental has processed your dentist's request for your treatment in accordance with Title 22, California Code of Regulations, Sections 51003, 51307, and the Manual of Criteria. At least one of the items cannot be approved or requires modification. Please refer to the enclosed list for an explanation of the REASON FOR ACTION CODE(S) listed. In addition, specific minimum requirements can be found in the Medi-Cal Dental Provider Handbook, under Section 5 entitled "MANUAL OF CRITERIA" under the specific Procedure Number listed below. A copy may be found at any Medi-Cal dentist's office.

Tooth # or Arch	Treatment Description	Procedure Number	Medi-Cal Dental Action	Reason for Action Code(s) (see enclosed for explanation)

- You can discuss different treatment plans with your dentist to obtain the best care allowable under the Medi-Cal Dental program.
- If you have a question regarding this action, please contact your dentist or Medi-Cal Dental at 1-800-322-6384 for a more detailed explanation.
- If you are dissatisfied with the action described on this notice, you may request a state hearing within 90 days from the Notice Date. Please see the back of this notice for information on filing a hearing.

IF YOU ARE DISSATISFIED WITH THE ACTION DESCRIBED
ON THIS NOTICE, YOU MAY REQUEST A STATE HEARING WITHIN 90
DAYS FROM THE NOTICE DATE.

To Request a Hearing:

SEND BOTH SIDES OF THIS ENTIRE NOTICE TO:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

OR

You may call the TOLL-FREE number at the Public Inquiry and Response
Unit. 1-800-952-5253 (ASSISTANCE AVAILABLE IN LANGUAGES
OTHER THAN ENGLISH)

OR

You may call the TDD toll-free number: 1-800-952-8349

State Regulations:

A copy of Title 22, California Code of Regulations, Sections 5095 1,5 1014.1, and
51014.2, which covers state hearings, is available at your county social services office or
local library.

Authorized Representative:

You can represent yourself at the hearing or you can be represented by a friend, lawyer
or any other person. You are expected to arrange for the representative yourself. You can
obtain the telephone numbers to legal aid organizations by calling the toll-free number of
the Public Inquiry and Response Unit or from your local Social Security Office.

I WILL NEED A TRANSLATOR (at no cost to me).

MY LANGUAGE OR DIALECT IS: _____

NONDISCRIMINATION NOTICE

Discrimination is against the law. The Medi-Cal Dental Program (Medi-Cal Dental Fee-For-Service) follows State and Federal civil rights laws. Medi-Cal Dental does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Medi-Cal Dental provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - ✓ Qualified sign language interpreters
 - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - ✓ Qualified interpreters
 - ✓ Information written in other languages

If you need these services, contact Medi-Cal Dental between 8 a.m. and 5 p.m. Monday through Friday by calling 1-800-322-6384. Or, if you cannot hear or speak well, please call 1-800-735-2922 for Teletext Typewriter (TTY) assistance. Have the operator call the Toll-Free member Line at 1-800-322-6384.

HOW TO FILE A GRIEVANCE

If you believe that Medi-Cal Dental has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Medi-Cal Dental. You can file a grievance by phone or in writing:

- **By phone:** Contact the Medi-Cal Dental Telephone Service Center between 8 a.m. and 5 p.m. Monday through Friday by calling 1-800-322-6384. Or, if you cannot hear or speak well, please call 1-800-735-2922.
- **In writing:** Fill out a complaint form or write a letter and send it to:

Medi-Cal Dental Program
Member Services Group
P. O. Box 15539
Sacramento, CA 95852-1539

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

Michele Villados
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at
http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.



REASON FOR ACTION CODES

- 01 Your eligibility (aid code) covers emergency services only.
- 02 **Information sent by your dentist about your current dental condition does not meet the minimum requirements for approval of this service.**
- 03 The request for dental treatment was changed. This change was based on the information sent by your dentist about your current dental condition or to follow program guidelines.
- 04 **Our records show this service(s), or a similar service(s) was previously approved, paid for, or completed. (For example: In some cases, procedures are limited to once in 12 months or once in five (5) years and cannot be approved again except under special conditions, which must be documented by your dentist.)**
- 05 We are unable to verify your dentist's enrollment in the program on the date the request was received.
- 06 **The service requested by your dental provider, is not a benefit of the program. Please contact your provider for a different treatment plan.**
- 07 You did not appear for a scheduled screening exam or failed to bring existing denture(s) (full or partial) to your appointment. Please contact your dentist to send a new request.
- 08 **Your dentist did not send enough information to allow us to process this request. Please contact your dentist for information about this treatment.**
- 09 X-rays show that the tooth does not meet the requirements for a crown. The tooth may be fixed with a filling.
- 10 **X-rays show that the tooth/teeth may have an infection; please contact your dentist as another service may be needed first.**
- 11 Based on x-rays, chart records and/or information confirmed by your clinical screening exam you do not need a deep cleaning.
- 12 **This service cannot be approved because it is related to a denied procedure in the same treatment plan sent by your dentist.**
- 13 Based on the information from your dentist and/or a clinical screening exam, your current dental condition is stable, and the requested service is not needed at this time.
- 14 **Based on x-rays and/or information confirmed by your clinical screening exam, the tooth/teeth has/have worn down naturally or has been caused by grinding your teeth. The requested service is not a benefit of the program unless there is decay or a broken tooth.**
- 15 X-rays show the tooth is too broken down and cannot be fixed. Your dentist may be able to offer a different treatment.
- 16 **Our records show that the tooth has been fixed with a filling or stainless steel crown.**
- 17 X-rays show the service asked for cannot be approved because gum disease has destroyed the bone around the tooth. Your dentist may be able to offer a different treatment.
- 18 **The minimum requirements for braces could not be verified.**
- 19 A partial denture can be a benefit only when there is a full denture on the opposite arch.
- 20 **Root canal treatment must be satisfactorily done before a crown can be considered.**
- 21 The tooth is not fully formed. Your dentist may be able to offer a different treatment.
- 22 **Treatment is not needed because the x-rays and documentation show that there is no nerve damage.**
- 23 A stayplate can be a benefit only to replace a missing permanent front tooth.

- 24 **X-rays show more extractions are needed before the treatment plan can be approved; please contact your dentist.**
- 25 Based on information sent by your dentist, your teeth are in such a poor condition that the requested partial denture is not a benefit under this program.
- 26 **Based on the information sent by your dentist, your teeth are fine and should not be replaced by a full denture.**
- 27 Based on the information sent by your dentist, you do not have a full denture on the opposite arch; therefore, you do not qualify for a metal partial. However, if you are missing front teeth, you qualify for a stayplate.
- 28 **Based on x-rays, documentation, and/ or information received from your screening exam, your teeth and/ or gums are in such poor condition that the requested treatment is not a benefit under this program. Your dentist may be able to offer a different treatment.**
- 29 Your request for dental services was returned to your dental provider for more information. Your provider has 45 days to resubmit the information requested. There is no action needed from you, but you may contact your dentist about this request. A request for a State Hearing is not an option at this time.
- 30 **Fixed bridges are allowable when a medical condition prevents the use of a removable denture.**
- 31 The tooth is not in its normal position and cannot be fixed under this program.
- 32 **Based on information received from a screening exam, your current denture is good at this time.**
- 33 Based on your recent screening exam, a denture is not the right treatment for you. Please contact your dentist for other options.
- 34 **The requested denture is not approved because there are enough teeth remaining in the arch to support the denture.**
- 35 During your screening exam, you said you do not want any dental services at this time or that you want to be seen by another dentist.
- 36 **The number of approved visits has been adjusted because you will be 21 years old before treatment is completed. Please contact your dentist.**
- 37 The tooth is not shown on the submitted x-rays.
- 38 **Based on x-rays and/or information received from your screening exam; you need additional treatment from your dentist before the procedure can be considered.**
- 39 X-rays show there is not enough space for the requested false tooth.
- 40 **This program does not cover braces when baby teeth are still present.**
- 41 Based on x-rays and information received from your screening exam, you grind your teeth. The program does not cover services for this condition.
- 42 **The procedure is not a benefit for a baby tooth or for a baby tooth ready to fall out. Your dentist may be able to offer a different treatment for your condition.**
- 43 The procedure requested will not fix your dental problem. Your dentist may be able to offer a different treatment for your condition.
- 44 **Based on information received from your dentist, the requested service is for cosmetic reasons only. Services for cosmetic purposes only are not a benefit of the program.**
- 45 Your current denture can be fixed by replacing the inner side of the denture.
- 46 **We are unable to verify your eligibility in this program.**
- 47 Your dentist must contact the California Children's Services program before submitting this procedure for payment or approval.
- 48 **EPSDT Services are not a benefit for patients 21 years and older.**
- 49 The EPSDT service(s) requested is not medically necessary.