CALIFORNIA MEDI-CAL DENTAL PROGRAM

BASIC AND EDI SEMINAR PACKET

Revised 11/01/2022

DHCS | Medi-Cal Dental

Dear Medi-Cal Dental Provider and Staff:

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

The material contained in the training packet has been prepared to help familiarize you with the Medi-Cal Dental Programs' policies, procedures and billing requirements. You should also refer to the Medi-Cal Dental Program Provider Handbook, located on the Medi-Cal Dental Program 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,

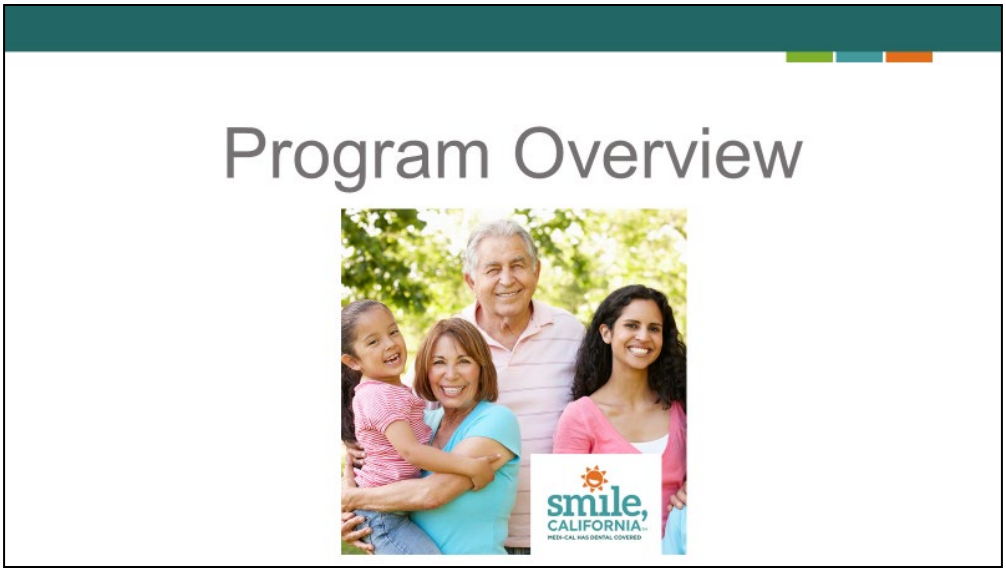
Medi-Cal Dental Program

P.O. Box 15609 • Sacramento, CA 95852-0609 • (800) 423-0507 • (916) 853-7373

Introduction

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

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



Program Overview

Medi-Cal Dental is the dental portion of the State Medicaid Program. Delta Dental of California administers the 'Fee-For-Service' portion of the dental program for the Department Of Health Care Services (DHCS). Our function as administrators of this program is to process your TAR/Claim forms, and to enforce the rules and guidelines set by DHCS.

Requirements for Providers

- Senate Bill 639 – Effective July 1, 2020
- See Bulletin Volume 36, Number 4 (March 2020): Enhanced Protections for Medi-Cal Members
- Contains provisions regarding lines of credit
- Requires that dentist provide a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs

Senate Bill 639

- 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

Record Keeping Criteria for the Medi-Cal Dental Program

The Surveillance and Utilization Review Subsystem (S/URS) department is responsible for overseeing and monitoring the California Medi-Cal Dental Program for suspected fraud, abuse, and poor quality of care.

The goal of the S/URS department is to ensure that providers and members are in compliance with the criteria and regulations of the Medi-Cal Dental program, and is governed by Title 22, the California Code of Regulations. Refer to Section 8 (FRAUD) in the Medi-Cal Dental Provider Handbook for further information.

Surveillance and Utilization Review Subsystem (S/URS)

(Title 22, the California Code of Regulations)

Record Keeping Criteria for the Medi-Cal Dental Program:

1. Complete members treatment records shall be retained for 10 years from the date the service was rendered and must be readily retrievable upon request.
2. 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
   - Indicate the type of materials used, anesthetic type, dosage, vasoconstrictor and number of carpules used
   - Prophylaxis and fluoride treatments
   - Include the date and ID of the enrolled provider who preformed the treatment
3. 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.

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 eligibility)	800-456-2387
A.E.V.S. Help Desk (Medi-Cal)	800-541-5555
P.O.S./Internet Help Desk	800-541-5555
Medi-Cal Website (to verify member eligibility)	www.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

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

Additional Services offered by The Medi-Cal Dental Program

Free Services Offered

- Toll Free Lines for
  - Providers 1-800-423-0507
  - Members 1-800-322-6384
- Interactive Voice Response System (IVR)
- Onsite Training Visits
- Seminars
- Case Management and Care Coordination Services
- American Sign Language(ASL) and Language Services

For additional information and services see page 66-73 of the printed packet

American Sign Language

Medi-Cal Dental reminds providers that American Sign Language (ASL) translation and language assistance services are available to Medi-Cal members at no cost.

- Provider or member can request language assistance by calling the Telephone Service Center (TSC)
- Language assistance over the telephone or to schedule an ASL translator to be present at the time of the appointment.
- Providers can supply a language interpreter in the office, or providers can call the TSC to access language interpreters available in 250 languages and dialects.
- Free language tagline signs are available:

https://smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

Language Assistance Services

- Provider requesting translator for member should call:

  Telephone Service Center at (800) 423-0507
- Member requesting Translator should call:

  Telephone Service Center at 1-800-322-6384
- Members with hearing or speaking limitations can call:

  Teletext Typewriter (TTY) line at (800) 735-2922

(Monday through Friday, 8 a.m. to 5 p.m. at all other times, Medi-Cal members should call the California Relay Service TDD/TTY at 711 to receive the help they need.)

Refer to bulletin volume 35, number 12, in the bulletin section of the Medi-Cal Dental website.

TELEPHONE INQUIRIES

Provider

For inquiries or general information, call the Medi-Cal Dental Program Customer Service Telephone Center toll-free at (800) 423-0507. When calling, please be prepared with the following information where applicable:

1. Billing provider name and provider number
2. Member's name and ID number
3. Type of treatment
4. Document Control Number of claim or TAR
6. Date of service and billed amount
7. Check voucher number

The TSC representatives are available to answer questions from 8:00 a.m. to 5:00 p.m. Monday through Friday (excluding holidays). The Medi-Cal Dental program encourages the use of the toll-free line for inquiries whenever possible. Most inquiries can be answered immediately by our telephone representatives. However, if the inquiry cannot be answered immediately, it will be routed to the telephone inquiry specialist and will be answered by mail within 10 days of the receipt of the original telephone call.

The Medi-Cal Dental program would like to give the best possible service and asks that the toll-free number be for provider assistance only. Please do not give the provider toll-free number to the Medi-Cal Dental members.

Medi-Cal Dental Members

The TSC toll-free line is available from 8:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays). The toll-free number is (800) 322-6384.

Members or their authorized representatives may use this toll-free number. Representatives must have the member's name and ID number in order to receive information from the California Medi-Cal Dental Program.

Information about the program is available from the member toll-free telephone operators. A few of the services are listed below:

1. Referrals to Medi-Cal Dental dentists
2. Complaints and grievances
3. Assistance with scheduling or rescheduling Clinical screenings
4. Information about Share of Cost and copayments
5. Information about denied, modified or deferred TARs

INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

The Medi-Cal Dental IVR is an automated inquiry system for use by providers. Using a touch-tone telephone, providers can communicate directly with an automated voice response system. Providers can access the IVR System by dialing the toll-free information line (800) 423-0507 from a touch tone telephone. The IVR 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 the Medi-Cal Dental Program
- Transfer to a telephone representative for further inquiry

The hours for accessing information requiring a provider number are Monday through Sunday from 2:00 a.m. to 12:00 midnight. The optimum time to call is between 6:00 a.m. and -10:00 a.m. or between 3:30 p.m. and 5:00 p.m. when calls are at there 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)

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:

1. If a provider is not a Medicare provider, indicate this in the comments section, Box 34 on the claim form. Submit the claim directly to the Medi-Cal Dental for reimbursement.

2. A provider must be enrolled with the Medicare program to be reimbursed by Medicare.

3. An enrolled Medicare provider may submit claims to the Medi-Cal Dental program for crossover procedures upon completion and approval of the MC 0804 Form. The provider must currently be enrolled in Medicare, must not be enrolled in the Medi-Cal Dental program, and must be providing services to dual eligible members. Existing Medi-Cal Dental providers do not need to complete this form. The MC 0804 Form may be obtained from the Medi-Cal Dental website or by calling the Toll-Free Provider line.

4. Approved and paid Medicare dental services do not require prior authorization from the Medi-Cal Dental program.

5. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a patient and has no direct bearing on the coverage or exclusion of any given procedure.

HOSPITAL CASES

When dental services are provided in an acute care general hospital or a surgicenter, 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 the Medi-Cal Dental program. Prior authorization is required only for the following services in a hospital setting: laboratory processed crowns/bridges, prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from the Medi-Cal Dental program, even if they are provided in an outpatient hospital setting. In all cases, an operating room report, or hospital discharge summary must be submitted with your 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 Medi-Cal member receives their medical benefits. Members may receive medical benefits 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 your Medi-Cal Dental Provider Handbook under “Section 4: Treating Members” to determine the entity providing a member medical services.

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

Authorization is required from Medi-Cal to admit the patient 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

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

If your patient requires emergency hospitalization, a 'verbal' authorization is not available through the Medi-Cal field office. If the patient 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 patient as an emergency case and submit the 50-1 retroactively within ten working days to the Medi-Cal field office.

Your claim for payment of dental services is submitted to the Medi-Cal Dental program 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 patient's medical plan to arrange for hospital or surgicenter 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 50-1 for a Medi-Cal patient who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

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 program. These codes are listed in your Medi-Cal Dental Provider Handbook.

ORTHODONTIC SERVICES

Orthodontic benefits for eligible individuals under the age of 21 are available under the California Medi-Cal Dental Program when medically necessary. Services must be performed by a qualified orthodontist who is enrolled as a Medi-Cal Dental provider. This program 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. To document a handicapping malocclusion, it is necessary to have a minimum score of 26 on the HLD score sheet. There are also six automatic qualifying conditions: cleft palate deformity, cranio-facial anomaly, a deep impinging overbite causing destruction of the palatal soft tissue, an anterior cross-bite causing clinical attachment loss and recession of the gingival margin, severe traumatic deviation, or an overjet greater than 9mm or a mandibular protrusion greater than 3.5mm. See Provider Handbook, page 9-11 for more information.

CALIFORNIA CHILDREN'S SERVICES (CCS)

The CCS program provides healthcare to children and adolescents under 21 years of age who have a CCS-eligible medical condition. Patients must apply to CCS to be eligible for services provided under this program. The patient's caseworker can refer the patient to his or her local CCS county or regional office.

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

Program 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. The CCS Program only authorizes dental services if such oral conditions affect the member's /CCS-eligible condition. See Provider Handbook, page 9-1: Special Programs, for more information.

CCS/Medi-Cal: The CCS program will no longer issue authorizations for CCS/Medi-Cal members. Providers are to submit all claims and TARs directly to the Medi-Cal Dental program. If a member requires services beyond the scope of the Medi-Cal Dental program, they may qualify for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

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 the Medi-Cal Dental program.

THE PROFESSIONAL COMPONENT

The Medi-Cal Dental program has a professional unit consisting of dental consultants who are licensed dentists. The consultants review all claims and TARs which require professional judgment. These dental consultants assist the Medi-Cal Dental Program 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 the Medi-Cal Dental program.

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

ONSITE TRAINING VISIT

Provider Representatives are available for On-site 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 on-site training visit. To request a visit please contact the Telephone Service Center at (800) 423-0507.

SEMINARS

There are four types of Medi-Cal Dental Seminars- Basic/EDI, Advanced, Workshops and Orthodontic. All seminars are free of charge and offer continuing education credits based on the hours of training conducted. Visit the Medi-Cal Dental website at www.dental.dhcs.ca.gov or you may contact the telephone service center for the current seminar schedule and to make a reservation.

American Sign Language(ASL) and Language Services

American Sign Language (ASL) translation and language assistance services are available to Medi-Cal members at no cost. Either the Medi-Cal dental provider office or the member can call the Telephone Service Center (TSC) Monday through Friday, between 8 a.m. and 5 p.m. to request language assistance over the telephone or to schedule an ASL translator to be present at the time of the appointment. Providers can supply a language interpreter in the office, or providers can call the TSC to access language interpreters available in 250 languages and dialects..

Medi-Cal dental providers should call the Provider Telephone Service Center at (800) 423-0507 and Medi-Cal members should call the Medi-Cal Dental Telephone Service Center at 1-800-322-6384. Members with hearing or speaking limitations can call the Teletext Typewriter (TTY) line at (800) 735-2922, Monday through Friday, 8 a.m. to 5 p.m. At all other times, Medi-Cal members should call the California Relay Service TDD/TTY at 711 to receive the help they need.

CASE MANAGEMENT

Dental Case Management is designed to assist Medi-Cal members with special health care needs who are unable to schedule and coordinate complex treatment plans among multiple practitioners. This is a program designed for members with mental, physical and/or behavioral diagnosis or diagnoses who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers.

Some examples of qualifying special healthcare needs include physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or other limiting condition that requires medical management, health care intervention and/or use of specialized services or programs.
Referrals for Case Management services are initiated by the members' Medi-Cal dental provider, medical provider, case manager or case worker 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. Members must be referred by a Medical or Dental professional by completing the secure online referral form. After completing the referral form, it must be emailed to DentalCaseManagement@delta.org. Please visit our Provider Forms Page/Dental Case Management section to download and submit a Case Management Referral form. If you have questions when submitting an online referral, please contact the Telephone Service Center at (800) 423-0507.

CARE COORDINATION SERVICES

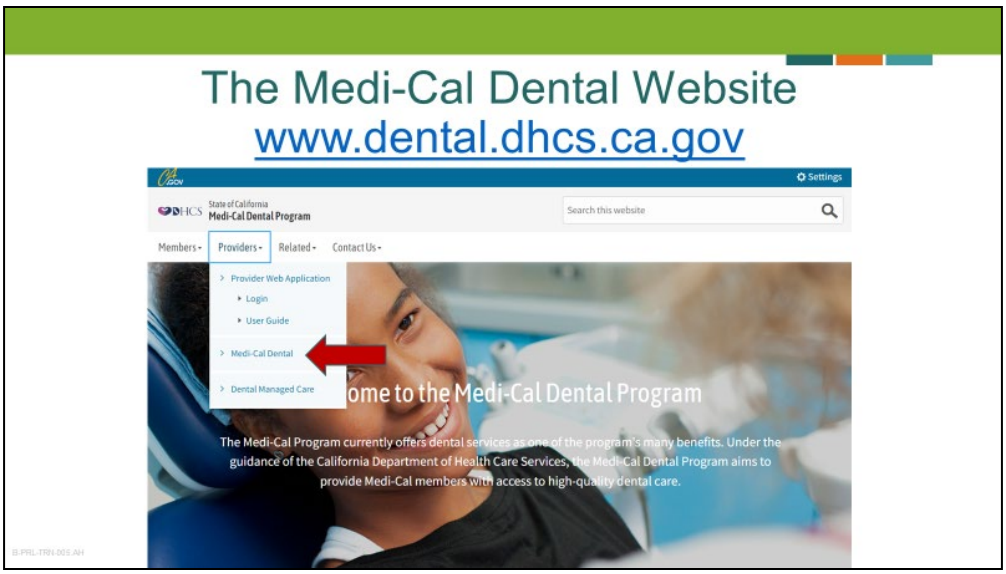
Care Coordination services are offered by the Telephone Service Center (TSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our TSC representatives, who assist members with: Locating a General or Specialist, Dentist, Accessing Appointments, Translation Services, Transportation Assistance
Members can access the Care Coordination Services by contacting the Telephone Service Center at (800) 423-0507, and request Care Coordination assistance.

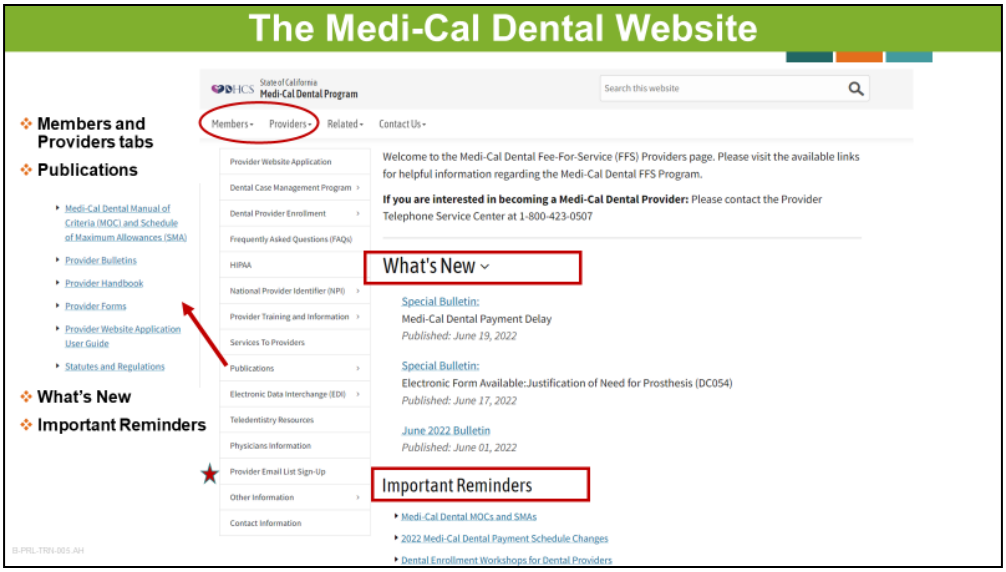
THE MEDI-CAL DENTAL PROVIDER HANDBOOK and BULLETINS

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.

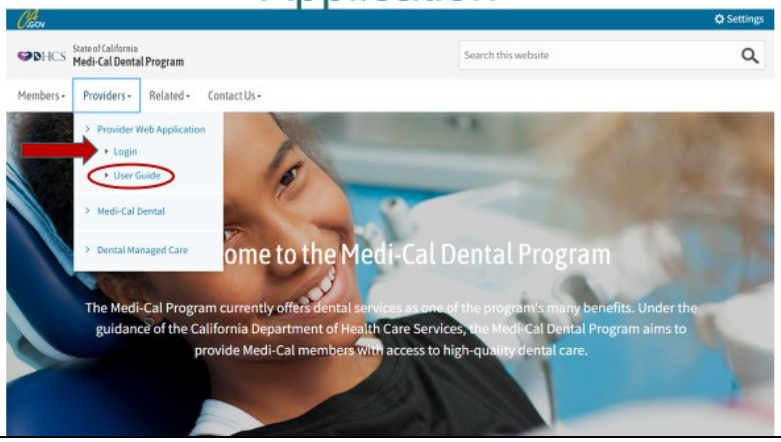
The Medi-Cal Dental Provider Handbook has been developed to assist the provider and office staff with participation in the Medi-Cal Dental program. It contains detailed information regarding the submission, processing and completion of all treatment forms and other related documents. The Handbook should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

The Medi-Cal Dental Bulletins are published periodically to keep providers informed of the latest developments in the program. 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 the Medi-Cal Dental program.





The Medi-Cal Dental Provider Website Application



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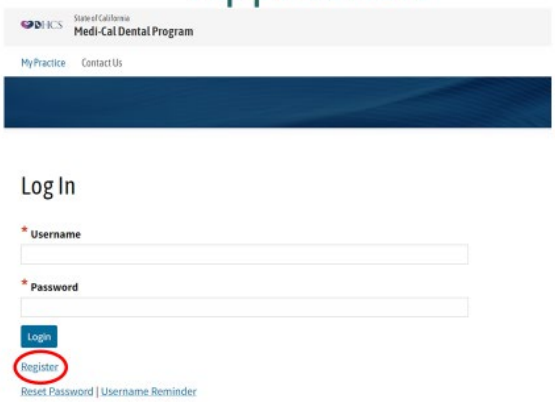

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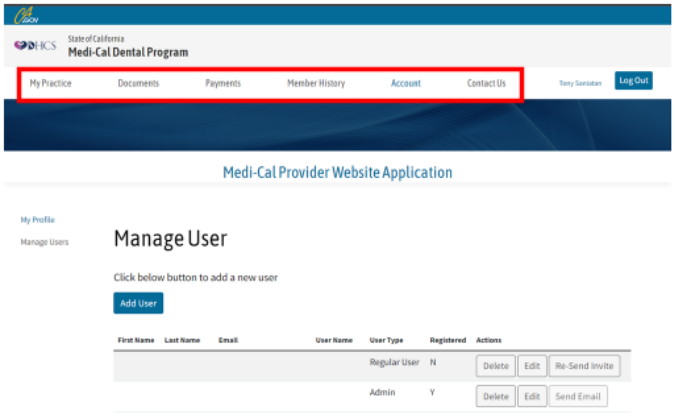
The Medi-Cal Dental Provider Website Application



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Enrollment

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

DHCS

BECOME A MEDI-CAL PROVIDER

ENROLL WITH PAVE

Provider Enrollment Division

PAVE NO MORE PAPER APPLICATIONS!

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Billing Providers

To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the 'Medi-Cal Dental Program'. Enrollment is completed through the Provider Application and Validation for Enrollment (PAVE) portal. The Provider Enrollment Division (PED) provides an online enrollment application process.

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 the program 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 're-order form' found on the Medi-Cal Dental Website.

RENDERING PROVIDERS

Each dentist who treats Medi-Cal patients must be enrolled in the Medi-Cal Dental program. 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 go 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 the billing service must complete (The Medi-Cal Dental Provider and Billing Intermediary Application/Agreement). 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.

What is PAVE?

- PAVE: Provider Application and Validation for Enrollment System
  - Interactive
  - Web-based
  - Secure
- PAVE is for:
  - Providers who want to enroll in Medi-Cal Fee-for-Service
  - For already enrolled Fee-for-Service providers who need to update their enrollment accounts

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Enrollment Changes

- All changes to your practice and/or license must be completed through the PED website, within 35 days of the change.
- PAVE Application https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

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Enrollment Revalidation

- Compliance with Centers for Medicare and Medicaid Services (CMS) Final Rule;
- The Code of Federal Regulations, Title 42, Section 455.414 states:

  The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

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Enrollment Revalidation Application Process

- DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application. Revalidation notices will be mailed to the service address enrolled with Medi-Cal. All providers are required to re-validate in order to continue participating in the Medi-Cal Dental Program.
- Dental providers submit revalidation applications using PAVE For more information, please contact PED using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx. You can also call the PED Message Center at (916) 323-1945.

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Enrollment Assistance

- For Medi-Cal provider enrollment information, please contact Provider Enrollment Division (PED) using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
- Provider Enrollment Division (PED) Message center
  - Phone number: (916) 323-1945
  - For Application questions email: PAVE@dhcs.ca.gov or send a message in PAVE
- PAVE Technical support
  - PAVE Help Desk at (866) 252-1949. The Help Desk is available Monday-Friday from 8:00 am-6:00 pm, excluding State holidays. You can also use the PAVE Chat feature while in PAVE. Chat is available Monday-Friday from 8:00 am-4:00 pm, excluding State holidays.

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Enrollment Inquiries

For Medi-Cal provider enrollment information, please contact PED using the Inquiry Form found on PED's website under 'Provider Resources' at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

You can also call the PED Message Center at (916) 323-1945. For PAVE application questions, email PED at PAVE@dhcs.ca.gov, or send a message in PAVE.

Revalidation Inquiries

Dental providers submit revalidation applications using PAVE. DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application. Revalidation notices will be mailed to the service address enrolled with Medi-Cal.

PAVE Technical Support

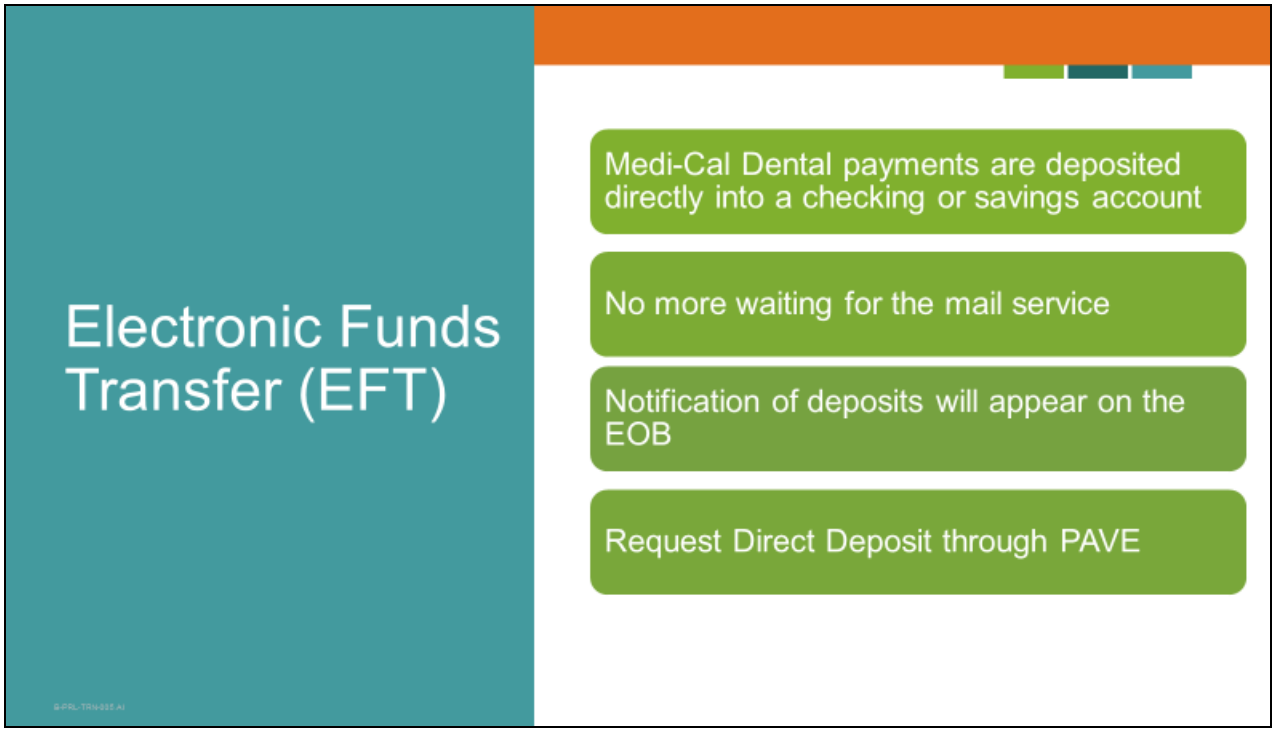
For PAVE technical support, please call the PAVE Help Desk at (866) 252-1949. The Help Desk is available Monday-Friday from 8:00 am-6:00 pm, excluding State holidays. You can also use the PAVE Chat feature while in PAVE. The Chat feature is available Monday-Friday from 8:00 am-4:00 pm, excluding State holidays.

Billing Inquiries and EFT Inquiries

Please call the Medi-Cal Dental Telephone Service Center (TSC) at (800) 423-0507. TSC Representatives are available Monday-Friday from 8:00 am-5:00 pm.

PIN Confirmation/Reset

To confirm or reset a PIN, send a written request to Medi-Cal Dental at PO Box 15609, Sacramento, CA 95852-0609. A PIN cannot be confirmed or reset over the telephone.



'Electronic Funds Transfer'

DIRECT DEPOSIT

Medi-Cal Dental check-write is 1 per week on Thursdays. And funds are deposited directly into your bank account on Wed night, and they would be available to you on Thursday morning. (Rather than Sat. or Monday with a paper check)

1. Enroll in Electronic Funds transfer through PAVE
2. No more waiting for the mail (or problems with lost checks/postal problems.
3. Notification of deposits will appear on your EOBs which will still go to the office (or wherever the Dr. directs).

Eligibility

MEDI-CAL MEMBERS IDENTIFICATION

Members are required to sign their Benefits Identification Card (BIC) prior to presenting the card for services. This requirement does not apply to persons 17 years of age or younger, or to those who reside in a long-term care facility.

Verification of identification is required for members who are unknown to the dental office except, when a member is 17 years of age or younger, is receiving emergency dental services, or resides in a long-term care facility. For all other members, the Medi-Cal Dental providers must make a "good-faith" effort to verify identification before providing Medi-Cal dental services. A good-faith effort means matching the name and signature on the BIC against the signature on a valid photo ID or any other document which appears to validate and establish identity.

Medi-Cal members who are unable to sign their name or make an "X" instead of a signature because of a disability are not required to sign their cards. Providers must still attempt to match the name on the BIC with an acceptable photo identification. If a provider does not attempt to identify a member and provides services to an ineligible member, payment for those services may be disallowed. 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.

If a provider suspects this type of fraud or abuse is occurring, he or she should report it immediately by calling the (800) 822-6222, Monday through Friday between 8:00 a.m. and 5:00 p.m.

The BIC is a permanent plastic card issued once. 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.

The BIC is NOT a verification of eligibility but DOES contain the information to enable the provider to access eligibility.

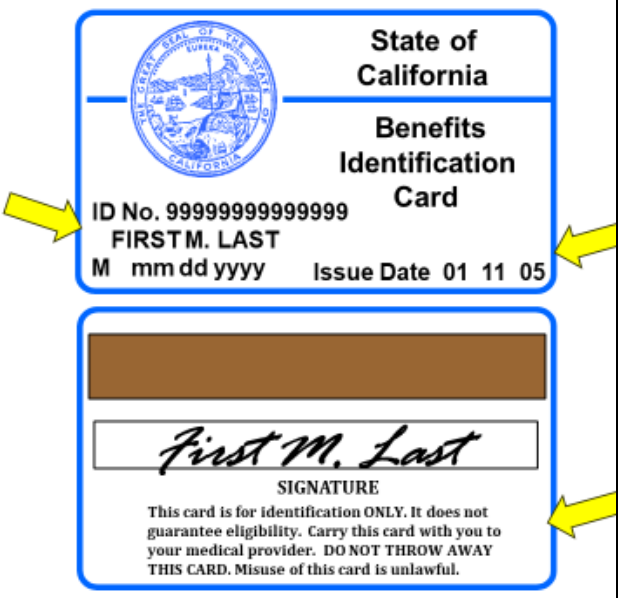
Providers have two methods available to verify eligibility information. The options are:

1. Touch-tone telephone
2. Internet access

Eligibility

- The County Department of Social Services establishes eligibility
- Information is transferred to the Department of Health Care Services (DHCS)
- Verify eligibility monthly
- Members turning 21 years of age
- Eligibility Verification Confirmation Number (EVC)

Medi-Cal Benefits Identification Card (BIC)



OPTIONS TO ACCESS THE POINT OF SERVICE (POS) NETWORK

The POS is set up to verify eligibility and perform Share of Cost (SOC) transactions. The network may be accessed through the following ways:

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 Share of Cost (SOC) information that is current and up-to-date. Please remember other information such as patient history or specific claim activity is available only through the Medi-Cal dental program. AEVS is accessible 22 hours a day, 7 days a week. The toll-free number to access AEVS is (800) 456-AEVS (2387).

Internet Access

The Medi-Cal website on the internet at www.medi-cal.ca.gov allows providers to verify eligibility and update Share of Cost liability. This secure site is accessed by using the billing provider number and PIN

Custom Applications

Providers with large claim volume and extensive computer systems may require custom applications to allow their system to interface with the POS network. The technical specifications to develop the program are available at no charge. The same eligibility and SOC information will be available to those using this method.

ELIGIBILITY VERIFICATION CONFIRMATION (EVC)

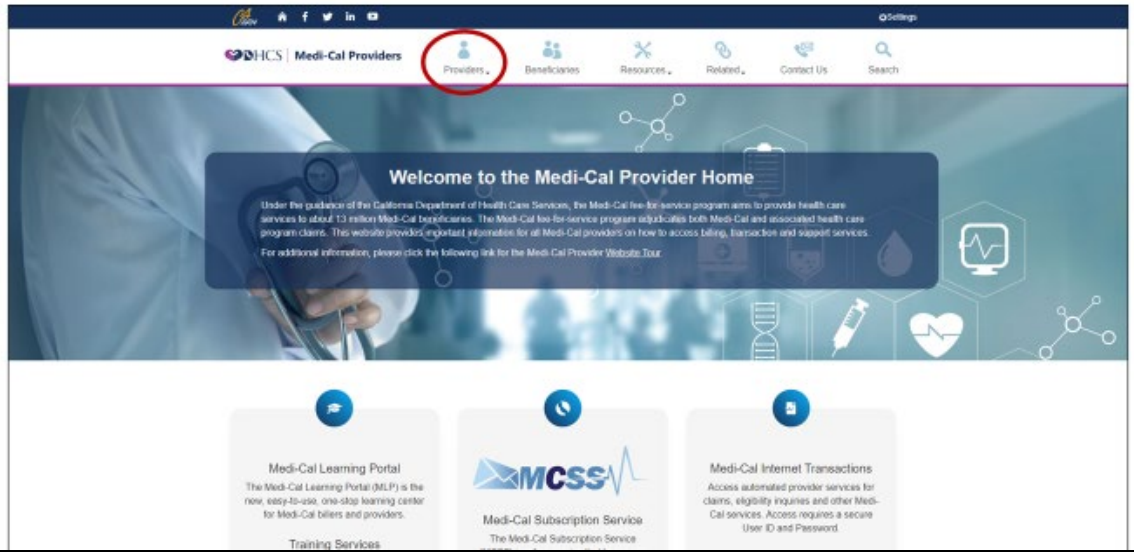
If the member's eligibility has been established for the month requested, an EVC number is received. This number should be recorded in the patient record. Please enter the EVC number in the field available on the Treatment Authorization Request (TAR)/Claim form, or in Box 23 on the Notice Of Authorization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

Eligibility

- The Medi-Cal program verifies eligibility
- Two ways to verify eligibility through the Point of Service (POS) Network
  1) Touch Tone Telephone (A.E.V.S.)
  2) Internet (www.medi-cal.ca.gov)
- Request a POS Network/Internet Agreement from the POS/Internet Help Desk or Medi-Cal

Web Eligibility

www.medi-cal.ca.gov



Web Eligibility
www.medi-cal.ca.gov

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Provider Enrollment
Enroll or re-enroll as a Medi-Cal provider

Transactions
Access automated provider services for claims, eligibility inquiry and other Medi-Cal services

New Provider
Welcome new providers, access content to help you get started with Medi-Cal

Publications
Access Medi-Cal Provider Manuals, Provider Bulletins and news

Outreach and Education
One-stop learning and resource center for Medi-Cal billers and providers

Medi-Cal Subscription Service
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Login to Medi-Cal

User ID

Password

Login

Services Available | Login Help

WARNING: This computer system is for official use by authorized users and may be monitored and/or restricted at any time. Confidential information may not be accessed or used without authorization. Unauthorized or improper use of this system may result in administrative discipline, civil and/or criminal penalties. By using this system, you are acknowledging and consenting to these terms and conditions. **LOG OFF IMMEDIATELY** if you are not an authorized user or do not agree to the conditions in this warning.

Transactions
- Login
- Services Available
- Enrollment Requirements

Provider
- Publications
- Outreach and Education
- MCSS

Support
- Contact Us
- References Page
- Site Map

Statewide Campaigns
- Register to Vote
- Save Our Water
- Report Medi-Cal Fraud

Website Accessibility Certification

Web Eligibility
www.medi-cal.ca.gov

Medi-Cal Transaction Services

Medi-Cal Rx is live on January 1, 2022. Please visit the Medi-Cal Rx site for additional information

Eligibility

- Eligibility Benefit Inquiry (270)
- Eligibility Benefit Response (271)
- Multiple Subscribers
- Single Subscriber
- Share of Cost (SOC)/Spend Down Clearance

Claims

- Appeal Status Inquiry
- Claim Status Inquiry
- Claim Status Request (276)
- Claim Status Response (277)
- Medical Services Reservation

Provider Services

- Blood Factor Rates
- Case Status Inquiry
- Continuing Care Inquiry
- Medical Supply Code Inquiry
- National Drug Code Inquiry
- Procedure Code Inquiry
- Provider Checkwrite Inquiry

Web Eligibility
www.medi-cal.ca.gov

Single Subscriber

* Indicates required field

Single Subscriber Eligibility

Swipe Card

Swipe Card

* Subscriber ID

Subscriber ID

* Subscriber Birth Date

mm/dd/yyyy

* Issue Date

mm/dd/yyyy

* Service Date

mm/dd/yyyy

Submit

Web Eligibility
www.medi-cal.ca.gov

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Home | Transaction Services | Single Subscriber | Single Subscriber Response

Single Subscriber Response

Eligibility transaction performed by provider: **on Thursday, January 13, 2022 at 4:52:39 PM**

Eligibility Message: NO RECORDED ELIGIBILITY FOR REQUESTED DATE OF SERVICE 01/13/2022.

Subscriber ID:

Service Date: 01/13/2022

Subscriber Birth Date:

Issue Date: 01/13/2022

Primary Aid Code:

First Special Aid Code:

Second Special Aid Code:

Third Special Aid Code:

Subscriber County: -unknown

HIC Number:

Primary Care Physician Phone #:

Service Type:

Trace Number (Eligibility Verification Confirmation (EVC) Number):

Additional Information

Aid Code information may be found in the Medi-Cal Dental Provider Handbook or on the Medi-Cal website

- ✓ Type of Benefits
- ✓ SOC

aid codes
1

Aid Codes Master Chart

Page updated: June 2021

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Automated Eligibility Verification System (AEVS). Providers must submit an inquiry to AEVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the SOC is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and public health program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing system and for other non Medi-Cal programs that need to verify eligibility through AEVS.

Note: Unless stated otherwise, these aid codes cover United States citizens, United States nationals and immigrants in a satisfactory immigration status. Satisfactory immigration status includes lawfully permanent residents, Permanent Residence Under Color of Law (PRUCOL) aliens and certain amnesty aliens.

Aid Codes Master Chart

Code	Benefits	SOC	Program/Description
+A1	Hearing aid and audiology	No	Non-Medi-Cal Hearing Aid Coverage for Children Program+
C1	Restricted to pregnancy-related, postpartum and emergency services	No	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – Medically Needy (MN). Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C2	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Aliens and Unverified Citizens. Covers eligible aliens who do not have satisfactory immigration status and unverified citizens. Aid to the Aged – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Part 1 – Aid Codes Master Chart

Aid Codes

The following aid codes identify the types of services for which different Medi-Cal/CMSP/CCS/GHPP members are eligible.

More information about OBRA and IICA aid codes can be found on the Medi-Cal website > Publications > Provider Manuals > Part 1-Medi-Cal Program and Eligibility > OBRA and IICA (obra).

Special Indicators: These indicators, which appear in the aid code portion of the county id number, help Medi-Cal identify the following:

- IE Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the 20C for other family members associated with the same case. Upon certification of the 20C, the IE individual is not eligible for Medi-Cal benefits in this case, an IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.
- RR Responsible Relative: An RR is allowed to use medical expenses to meet the 20C for other family members for which he/she is responsible. Upon certification of the 20C, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal budget unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

Aid Code	Benefits	SOC	Program/Description
0A	Full Scope	No	Refugee Cash Assistance (RF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	MP services only (no Medi-Cal)	No	Access for Infants and Mothers (AIM) - Infants enrolled in Healthy Families (HF), infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
0E	Full Scope	No	Medi-Cal Access Prog Preg Women >133% through 322%
0F	Full Scope	No	Five Month transitional food stamp program. This aid code is for households who are terminating their participation in the CalWORKs program without the need to re-establish food stamp eligibility.
0G	Full Scope	No	MCAP Pregnant Women >133% < 1522% FPL FPL
0HH	Full Scope	No	Accelerated Enrollment (AE) of temporary, full scope, no share of cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.
0N	Full Scope	No	AE of temporary, full scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, found in need of treatment, and who have no creditable health insurance coverage. No time limit.

2021 Treating
Page 4-23

Aid Codes

Not everyone receiving Medi-Cal has full-scope benefits

- Limited Services
- Restricted Services
  - Emergency Services Only
    - Require an 'Emergency Certification Statement'

DO NOT WRITE IN THIS AREA

TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

DHCS - Medi-Cal Dental
P.O. BOX 13010
SACRAMENTO, CALIFORNIA 95852-3010
Phone 800-322-6384

1. PATIENT NAME (LAST, FIRST, M.I.): Last, First
2. SEX: X
3. PATIENT BIRTH DATE: MM DD YY
5. MEDICAL BENEFITS ID NUMBER: 999999999999
4. PATIENT ADDRESS: Address
7. PATIENT DENTAL RECORD NUMBER:
CITY, STATE: Address
ZIP CODE: 00000
8. REFERRING PROVIDER NPI:
6. RADIOGRAPHS ATTACHED? CHECK IF YES
11. ACCIDENT INJURY? CHECK IF YES
EMPLOYMENT RELATED? YES
10. OTHER DENTAL COVERAGE? CHECK IF YES
14. MEDICARE DENTAL COVERAGE? YES
16. CHCP - CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES
17. CALIFORNIA CHILDREN SERVICES? YES
MONTHLY? _____
9. OTHER ATTACHMENTS? YES
12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES
13. RETROACTIVE ELIGIBILITY (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES
18. NP-C - NON-LICENSED - EMERGENCY SERVICES? YES
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.): Adams, James DDS
20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street
TELEPHONE NUMBER: (333) 333-3333
CITY, STATE: Anytown, CA
ZIP CODE: 95814
22. PLACE OF SERVICE: 1 2 3 4 5 6 7 8
23. ELIGIBILITY (PLEASE SPECIFY):

BIC Issue Date: MM DD YY
EVC #: 123456CN12

EXAMINATION AND TREATMENT

25. TOOTH NO. OR ORAL AREA	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING SHADES, PROSTHESES, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUADRANT	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
8		1 Extraction of erupted tooth	MM DD YY		D7140	$5.00	1111111122
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS: #8 Pain and swelling – periapical abscess. John Smith, DDS

35. PATIENT SHARE OF COST AMOUNT
37. OTHER INSURANCE AMOUNT
36. DATE RELIED: mm dd yy

X Mary Smith — SIGNATURE
MM DD YY — DATE

IMPORTANT NOTICE: IN ORDER TO REVIEW YOUR CLAIM, PROVIDE ALL PERTINENT INFORMATION INCLUDING ANY RADIOGRAPHS, IF APPLICABLE, MUST BE ATTACHED TO THIS FORM.

Aid Codes

Emergency services only aid codes (for OBRA members) contain specific emergency procedures, regardless of age

- See Section 4 for the allowable procedures

Managed Care Plans

- Member must go to a plan provider

Eligibility Message:
SUBSCRIBER LAST NAME: XXXXXX. EVC# 00000AKEOR. CNTY CODE: 19. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER:PHP-HLTH NET: MEDICAL CALL (800)000-0000. HPC: CALL (800) 000-0000 FOR HCP INFORMATION. PCP: DR. XXXXX XXXX CALL (000) 000-0000.
ACCESS DENTAL PLAN: DENTAL CALL (000) 000-0000.

Name: Last, First M.	Subscriber ID: 90000000A
Service Date: MM/DD/YYYY	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:	Subscriber County: 19 – Los Angeles
HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number: OOOOOAKEOR	

Other Insurance Coverage

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

Eligibility Message:
SUBSCRIBER LAST NAME: XXXXXX. EVC# 00000AKEOR. CNTY CODE: 11. PRIMARY AID CODE: 00. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV. UNDER CODE V. CARRIER NAME: BLUE CROSS OF CALIFORNIA ID XXXX000XXX00. COV OMIPDVR

Name: Last, First M.	Subscriber ID: 90000000A
Service Date: MM/DD/YYYY	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:	Subscriber County: 11– Glenn
HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number: OOOOOAKEOR	

Share of Cost

- Is a pre-set amount determined by DHCS for an individual or family
- Any Health Care Services may be used
- Updating SOC
- Case Numbers
- Non-Covered Services may be used to meet SOC

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)
- Providers are not to collect SOC amounts from the Working Disabled Program recipients.
- www.dhcs.ca.gov/services/Pages/TPLRD_WD_cont.aspx

Updating share of cost thru the POS network

EXAMPLE: Patient share of cost is $87.00

Description	Date of Service	Procedure Code	UCR Fee	Patient 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 the Medi-Cal Dental program for all services provided.

Member Dental Cap

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

Cap has relaxed

Benefits Table Guide

Age / Aid Code	Full Scope Benefits	Table 4 Emergency
Full Scope aid code • Child (under 21) • Adult (21 and over) • Member resides in an ICF or SNF • DDS Member	X	
All Ages – Emergency/Pregnancy aid code – Member is NOT pregnant/postpartum		X
Member is pregnant/postpartum (regardless of age and aid code)	X	

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

- These patients are eligible for additional services
- Services do not have to be provided in the facility to be payable benefits
- Use the website to confirm the classification and licensing of a facility (not all facilities qualify):

https://www.cdph.ca.gov/programs/chcq/lcp/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 MOC
- Includes 12 months of postpartum
- All requirements and criteria must be met
- Must document 'Pregnant' or 'Postpartum'

California Advancing and Innovating Medi-Cal

CalAIM

Overview of CalAIM

- CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal population by implementing a broad delivery system, program and payment reform across the Medi-Cal program.
- The major components of CalAIM were the successful outcomes of various pilots (including the Dental Transformation Initiative) from the previous federal waivers.
- All fee for service (FFS) claims will be processed and paid in accordance with the Manual of Criteria (MOC) and the Schedule of Maximum Allowances (SMA)

CalAIM effective January 1, 2022

CalAIM includes three oral health initiatives:

Preventive Services- Pay for Performance (P4P)

- To increase statewide utilization of preventive services.

Caries Risk Assessment and Silver Diamine Fluoride Benefits

- Caries Risk Assessment (CRA) bundle including the allowable increased frequencies for moderate and high-risk CRA bundles and Silver Diamine Fluoride (SDF) as new statewide dental benefits in alignment with national dental care standards

Continuity of Care- Pay for Performance (P4P)

- A flat rate performance payment to dental provider service office locations that maintain dental continuity of care by establishing a dental home for each patient and perform at least a yearly dental exam/evaluation for two or more years in a row.

CalAIM– Preventive Services

- Performance payments will be included in the weekly checkwrite 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	X		
D1206	TOPICAL APPLICATION OF FLUORIDE – VARNISH (CHILD 0 TO 5)	$18.00	$13.50	X		
D1206	TOPICAL APPLICATION OF FLUORIDE – VARNISH (CHILD 6 TO 20)	$8.00	$6.00	X		
D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH (CHILD 0 TO 5)	18.00	$13.50	X		
D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH (CHILD 6 TO 20)	$8.00	$6.00	X		
D1351	SEALANT – PER TOOTH	$22.00	$16.50	X		
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT – PERMANENT TOOTH	$22.00	$16.50	X		
D1510	SPACE MAINTAINER – FIXED – UNILATERAL – PER QUADRANT	$120.00	$90.00		X	
D1516	SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY	$200.00	$150.00		X	
D1517	SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR	$200.00	$150.00		X	
D1526	SPACE MAINTAINER – REMOVABLE – BILATERAL, MAXILLARY	$230.00	$172.50		X	
D1527	SPACE MAINTAINER – REMOVABLE – BILATERAL, MANDIBULAR	$230.00	$172.50		X	
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY	$30.00	$22.50		X	
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		X	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT	$30.00	$22.50	X		
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY	$30.00	$22.50	X		
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR	$30.00	$22.50	X		
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL – PER QUADRANT	$120.00	$90.00		X	
D1320	TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE	$10.00	$7.50			X
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT.	$46.00	$34.50			X

CalAIM– CRA and SDF Benefits

- To receive payment for the Caries Risk Assessment (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
- Dental providers with an active status, have completed an attestation form and TYKE training during DTI domain 2 are not required to complete these again

CalAIM CRA Benefit

CRA bundles includes the CRA exam (D0601, D0602, D0603) and nutritional counseling (D1310). Based on the risk level associated with each Medi-Cal member (ages 0-6)

- Caries Risk Assessment ($15.00)
  - D0601 = Low Risk
  - D0602 = Moderate Risk
  - D0603 = High Risk
- Nutritional counseling: D1310 ($46.00)
  - D1310

Additional services such as cleaning, fluoride, and exam can be rendered based on the risk level.

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

CalAIM Benefit – Caries Arresting Medicament

Silver Diamine Fluoride (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.

- It is paid $12 per tooth

D1354 – Caries Arresting Medicament

- Requires a tooth code
- A benefit
  - For members under age 7
    - Photograph required
    - Flexibilities allowed for members under age 4 (per SB 1403)
  - For members age 7 or older, in addition to a current intraoral photograph, must submit a current, diagnostic periapical radiograph and must document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal
  - D1354 is a benefit once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth

CalAIM– Continuity of Care

- This pay-for-performance payment offers a flat rate payment to dental provider service office locations Fee For Service (FFS) and Safety Net Clinics (SNCs) that maintain dental continuity of care by establishing a dental home for each patient and perform at least a yearly dental exam/evaluation for two or more years in a row.
- Paid at the flat rate of $55 once per year in addition to the SMA. This payment will be included in the weekly checkwrite for the FFS delivery system.
- 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 2021	CALENDAR YEAR 2022
D0120, D0145, D0150	X	X

Continuity of Care Dental Codes

- Service office locations are eligible to earn performance payments on one service performed annually using any of the specified codes depicted below at the flat rate of $55.

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

Resources and Forms

DHCS website

https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx

- Treating Young Kids Everyday (TYKE) training
- Caries Risk Assessment (CRA) form
- Attestation form

Questions about CalAIM

dental@dhcs.ca.gov

Medi-Cal Dental
EDI

Electronic

Data

Interchange

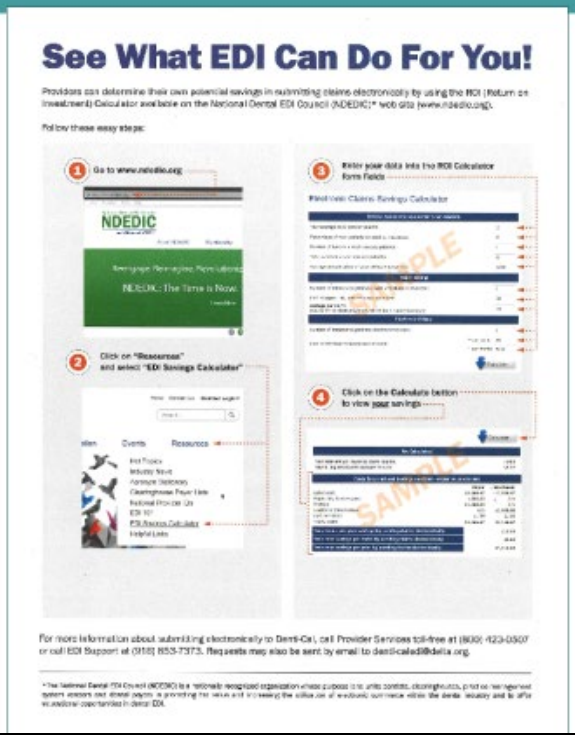
Did You Know?

- Medi-Cal Dental has been accepting EDI documents since 1994
- EDI claims are processed an average of five days faster than paper claims
- Over 70% of Medi-Cal's Dental incoming documents are received electronically

Why EDI?

- To maximize computer capabilities
- To make billing simpler
- To have fewer rejections
- To have tracking capabilities
- To receive payment faster
- Saves Money - Estimate your savings on the NDEDIC website

1. From the website: www.ndedic.org
2. Click on the 'Resources' Tab and select the 'EDI Savings Calculator'
3. Enter your data
4. Click 'Calculate' to see your savings



Getting Started With EDI

- Must have practice management software or access to the Internet
- If necessary, enroll with the clearinghouse that works with the office's practice management software
- Must enroll with the Medi-Cal Dental, EDI Department
- Do not send electronically until the office has been notified of activation by the Medi-Cal Dental program
- Take a few minutes to read the EDI How-to Guide

When Preparing An EDI Document…

Complete	Complete required fields
Check	Check for accurate information
Use	Use the comment or note section of the software to provide additional written information
Use	Use only the current CDT procedure code format

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 Program
EDI
REPORTS

B-PRL-TRN-005.AB

Daily EDI Documents Received Today
CP-O-973-P

```
REPORT ID:    CP-O-973-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                    PAGE:        1
PROGRAM ID:    DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY

PROV/SVC    PROVIDER            BASE        RECIPIENT    NAME        SSN/CIN/
OR NPI      DCN                 DCN         LAST         FIRST       OR MEDS
---------- ------------------ ----------- ------------ ---------- ---------
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    30.00
0000000000 G00000000          000000000 LA            FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   200.00
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    55.00
0000000000 G00000000          YY000000000 LAST         FIRST       0000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    77.00
0000000000 G00000000          YY000000000 LAST         FIRST       0000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   331.00
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR:                  DOC TYPE: C   SUBMITTED FEE:  1430.00
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    30.00
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   100.00
0000000000 G00000000          YY000000000 LAST         FIRST       000000000
MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:    50.00
        TOTAL PROV/SVC OFC DOCUMENTS :     9
```

Provider/Service Office Document Rejections Report

CP-O-959-P

```
REPORT ID:      CP-O-959-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
PERIOD ENDING:  MM/DD/YY        PROVIDER/SVC OFC                   PAGE:  1
PROGRAM ID:     DCB969BS   ... DOCUMENT REJECTIONS ........

PROV/SVC       PROVIDER        RECIPIENT  NAME      D  SSN/CIN              RSN
 OR NPI          DCN            LAST       FIRST     T  OR MEDS    BASE DCN  CD
---------     ----------       ---------------       --------  - --------- --------
0000000000    000000000         LAST       FIRST        C                    A
0000000000    000000000         LAST       FIRST        C                    A
0000000000    000000000         LAST       FIRST        C                    G

    PROVIDER/SERVICE OFC TOTALS

      A - INVALID PROV/SVC OFC    :    2
      B - INVALID C/H             :    0
      C - INVALID PROV/CH         :    0
      D - BATCH REJECTED          :    0
      E - RECORD COUNTS MISMATCH  :    0
      F - INVALID PROVIDER NAME   :    0
      G - DUPLICATE DOCUMENTS     :    1
      H - SECOND NOA ISSUED       :    0
      I - INVALID RETURN DCN      :    0
      J - SUB/PROV/SITE MISMATCH  :    0
      K - CLM OVR 90 LINES - 4010:     0
      L - USE CIN OR BIC-NOT SSN  :    0
      M - FILE VERSION NOT AUTH   :    0
      N - PDCN REQUIRED           :    0
      P - CLM OVR 50 LINES - 5010:     0

      TOTAL  REJECTIONS           :    3
```

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

```
    REPORT ID:      CP-O-973-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
    PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                    PAGE:        1
    PROGRAM ID:     DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY

*PROV/SVC    PROVIDER           BASE        RECIPIENT    NAME       SSN/CIN/
* OR NPI     DCN                DCN         LAST         FIRST      OR MEDS
*----------- ------------------ ----------- ------------ ---------- ---------
*0000000000 MCD141             YYXXXXXXXXX FIRST        NAME       000000000   MM/DD/YY
* MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:   117.00
*0000000000 Y0000000000000000 YYXXXXXXXXX FIRST        NAME       000000000   MM/DD/YY
* MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:    90.00
*0000000000 Y0000000000000000 YYXXXXXXXXX FIRST        NAME       000000000
* MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:   219.00
*0000000000 Y0000000000000000 YYXXXXXXXXX FIRST        NAME       000000000
* MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:    17.00

*    TOTAL PROV/SVC OFC DOCUMENTS :     4
```

- Indicate the date each claim is processed on the CP-O-973-P report
- Remove page once all claims are processed
- This quickly identifies the claims that have not been processed at the end of each month

Claims with Attachments

- Using the Base DCN listed on the report id: CP-O-971-P, mail radiographs to the Medi-Cal Dental program using special EDI labels and red bordered envelopes

or

- If the office is 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 the Medi-Cal Dental program

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#9999999/CHC#9999999)

- The date on the radiographs should match the "image created date" (or the date the film/sensor was actually in the patient's mouth)

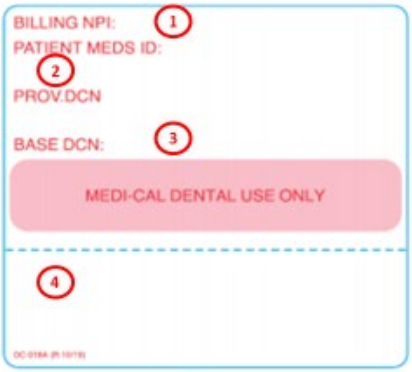
Digitized Images

- Offices using a digitized imaging company to submit radiographs and attachments, should still be familiar with the label process
- If radiographs or attachments are not successfully submitted using digitized imaging, the office will receive the CP-O-971-P report
- It will then be necessary to submit radiographs and attachments using the label process

EDI Labels

Labels must include:

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



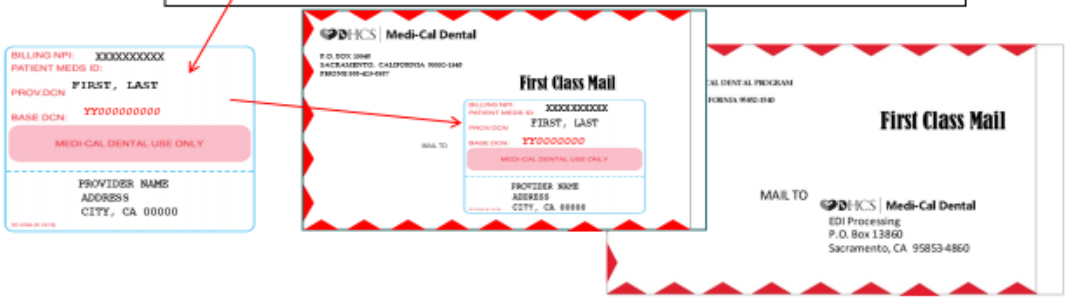
Claims With Attachments

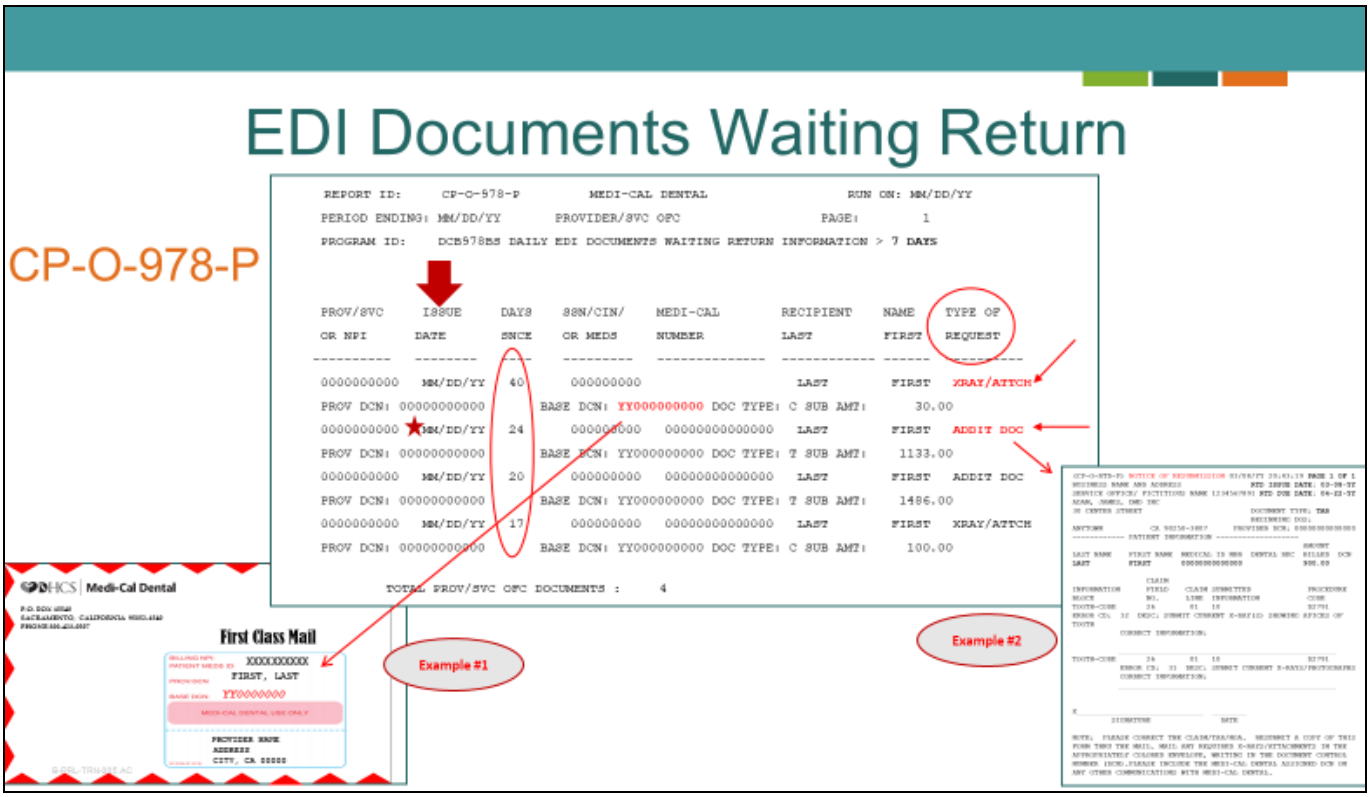
CP-O-971-P

```
REPORT ID:      CP-O-971-P          MEDI-CAL DENTAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY        PROVIDER/SVC OFC                    PAGE:        1
PROGRAM ID:     DCB971BS    X-RAY/ATTACHMENT REQUEST

  PROV/SVC   BASE          PROV                RECIPENT     NAME        SSN/CIN/
   OR NPI    DCN           DCN                 LAST         FIRST       OR MEDS
 ----------  ------------  ------------------  ------------ ----------  ---------
 0000000000 YY000000000  00000000000000000  LAST         FIRST
 MEDI CAL NBR: 000000000      SYS IND: *** DOC TYPE: C SUBMIT AMOUNT:    30.00
0000000000  YY000000000  00000000000000000  LAST         FIRST
MEDI CAL NBR: 000000000      SYS IND: *** DOC TYPE: T SUBMIT AMOUNT:   200.00
0000000000  YY000000000  00000000000000000  LAST         FIRST
MEDI CAL NBR: 000000000      SYS IND: *** DOC TYPE: C SUBMIT AMOUNT:  1430.00
0000000000  YY000000000  00000000000000000  LAST         FIRST
MEDI CAL NBR: 000000000      SYS IND: *** DOC TYPE: C SUBMIT AMOUNT:   100.00

** TOTAL X-RAY/ATTACHMENT REQUESTS FOR PROV/SVC OFC.:      4
```




EDI Documents Waiting Return
CP-O-978-P
REPORT ID: CP-O-978-P MEDI-CAL DENTAL RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY PROVIDER/SVC OFC PAGE: 1
PROGRAM ID: DCB978BS DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > 7 DAYS
PROV/SVC OR NPI
ISSUE DATE
DAYS SNCE
SSN/CIN/ OR MEDS
MEDI-CAL NUMBER
RECIPIENT LAST
NAME FIRST
TYPE OF REQUEST
0000000000 MM/DD/YY 40 000000000 LAST FIRST XRAY/ATTCH
PROV DCN: 00000000000 BASE DCN: YY000000000 DOC TYPE: C SUB AMT: 30.00
0000000000 MM/DD/YY 24 000000000 00000000000000 LAST FIRST ADDIT DOC
PROV DCN: 00000000000 BASE DCN: YY000000000 DOC TYPE: T SUB AMT: 1133.00
0000000000 MM/DD/YY 20 000000000 00000000000000 LAST FIRST ADDIT DOC
PROV DCN: 00000000000 BASE DCN: YY000000000 DOC TYPE: T SUB AMT: 1486.00
0000000000 MM/DD/YY 17 000000000 00000000000000 LAST FIRST XRAY/ATTCH
PROV DCN: 00000000000 BASE DCN: YY000000000 DOC TYPE: C SUB AMT: 100.00
TOTAL PROV/SVC OFC DOCUMENTS : 4
Medi-Cal Dental
First Class Mail
XXXXXXXXX
FIRST, LAST
YY0000000
Example #1
Example #2

smile, CALIFORNIA
MEDI-CAL HAS DENTAL COVERED
Electronic RTD and NOA
B-PRL-TRN-005.AB

CP-O-RTD-P

Notice of Resubmission

RTD

```
(CP-O-RTD-P)    NOTICE OF RESUBMISSION          MM/DD/YY 20:43:19 PAGE  01 OF 01
BUSINESS NAME AND ADDRESS                                RTD ISSUE DATE: MM/DD/YY
SERVICE OFFICE/ FICTITIOUS NAME          1234567891      RTD DUE DATE: MM/DD/YY
ADAM, JAMES, DMD INC

30 CENTER STREET                                  DOCUMENT TYPE: TAR
                                                  BEGINNING DOS:
ANYTOWN          CA 90250-3807                    PROVIDER DCN : 000000000000000
------------PATIENT INFORMATION -------------------
                                                        AMOUNT
LAST NAME    FIRST NAME  MEDICAL ID NBR  DENTAL REC      BILLED      DCN
LAST         FIRST       00000000000000                 900.00      YY000000000 7

                CLAIM
INFORMATION     FIELD    CLAIM SUBMITTED            PROCEDURE
BLOCK           NO.      LINE  INFORMATION          CODE
TOOTH-CODE      26        01   10                   D2791
          ERROR CD:  32  DESC: SUBMIT CURRENT X-RAY(S) SHOWING APICES OF TOOTH
          CORRECT INFORMATION:
                    ____________________________________________________

TOOTH-CODE      26        01   10                   D2791
          ERROR CD:  31  DESC: SUBMIT CURRENT X-RAYS/PHOTOGRAPHS
          CORRECT INFORMATION:
                    ____________________________________________________


X_____________________________  _______
        SIGNATURE                DATE

NOTE:  PLEASE CORRECT THE CLAIM/TAR/NOA.  RESUBMIT A COPY OF THIS FORM THRU THE
MAIL.  MAIL ANY REQUIRED X-RAYS/ATTACHMENTS IN THE APPROPRIATELY COLORED ENVELOPE,
WRITING IN THE DOCUMENT CONTROL NUMBER (DCN).  PLEASE INCLUDE THE MEDI-CAL DENTAL
ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH MEDI-CAL DENTAL.
```

B-PRL-TRN-005.AA

CP-O-NOA-P

Notice of Authorization

NOA

```
(CP-O-NOA-P)      NOTICE OF AUTHORIZATION    MM/DD/YY 01:43:53   PAGE 01 OF 01
DCN: YY000000000 7   AUTHORIZATION PERIOD FROM MM/DD/YY TO MM/DD/YY

                                        RE-EVALUATION IS REQUESTED _ (X FOR YES)

PATIENT NAME(LAST,FIRST,MI)                SEX  BIRTHDATE  MEDI-CAL-ID NO
LAST         FIRST                          M   XX/XX/XX   00000000000000
                                 PATIENT DENTAL RECORD NO.  :
                                 PROVIDER DOC CONTROL NUMBER: Y0ABZV01CROMY00-0
X-RAYS ATTACHED _  (X FOR YES) HOW MANY?  __    ACCIDENT / INJURY  _ (X FOR YES)
OTHER ATTACHMENTS _ (X FOR YES)                 EMPLOYMENT RELATED _ (X FOR YES)
OTHER DENTAL COVERAGE  _ (X FOR YES)            CHDP               _ (X FOR YES)

BUSINESS NAME AND ADDRESS      1234567891
ADAM, JAMES, DDS APC                              BIC ISSUE DATE:_____________

30 CENTER STREET
                                                  EVC #:_____________________
ANYTOWN          CA 90250-3807

TO SURF  LN DESCRIPTION-OF-SVC   DATE-PER QTY PROC   FEE    ALLOW  ADJ-C PROVID
18       01 PREFABRICATED POST   _______ 01 D2954  100.00   74.25        _____
18       02 FULL CAST METAL CROW _______ 01 D2791  800.00  336.60        _____

DATE PROSTHESIS ORDERED : _________      TOTAL FEE CHARGED              900.00
PROSTHESIS LINE ITEM    : __ __ __ __    TOTAL ALLOWANCE                410.85
                                         PATIENT SHARE-OF-COST AMT.  _______
                                         OTHER COVERAGE AMT.         _______
COMMENTS:                                DATE BILLED                 _______
PAYMENT REQUEST MUST HAVE RENDERING PROV ID
** PLEASE NOTE:  THIS MEMBER MAY ONLY BE ELIGIBLE
UNDER A PHP, MCP, GMC, HMO OR DMC WHICH INCLUDES DENTAL.
PLEASE VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICES.

                                         X_____________________  _______
                                                SIGNATURE          DATE

NOTE: PLEASE REFER TO THIS NBR (13000000000) ON ALL YOUR COMMUNICATIONS, WITH
      MEDI-CAL DENTAL, INCLUDING ELECTRONIC TRANSACTIONS CONCERNING THIS
DOCUMENT.
```

B-PRL-TRN-005.AA

EDI
Document Control Numbers

- How to identify EDI claims on an EOB?
- All EDI Document Control Numbers (Base DCN) have a “6”, “8” or “9” as the 7th digit

Example: YY00918XXXX

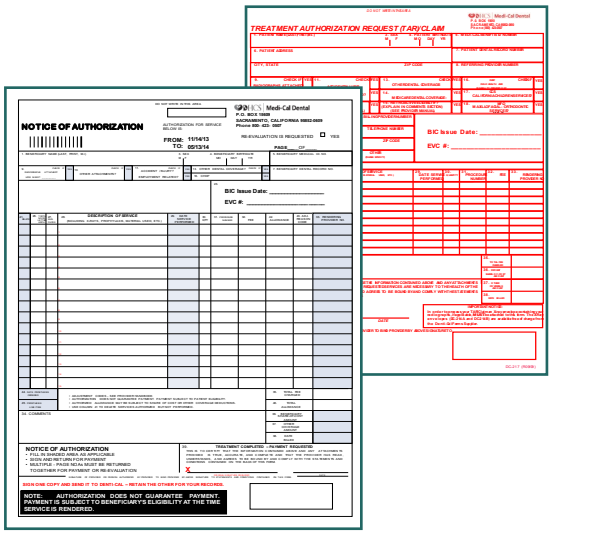
EDI Support

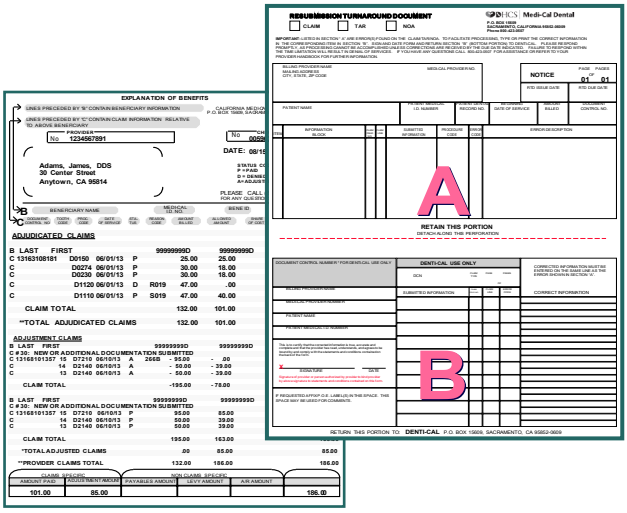
Please contact the EDI department for additional information:

EDI Support may be reached by phone or email at:
(916) 853-7373
medi-caldentaledi@delta.org

Provider Forms

- TAR / Claim Form
- NOA
- RTD
- EOB





Claims Processing Flow Chart

Input Prep

- Receives forms from provider
- Sorts by document type
- Assigns control numbers
- Scans documents and attachments

Data Correction

- Corrects / verifies input data
- Forwards input documents to appropriate data control center (DCC) for further action as directed by the system

File Maintenance

- Restores discrepancies between database file information and input data
- Forwards resolved documents to appropriate DCC as directed by the system

Enrollment

- Enrolls providers into program
- Updates information in Provider Master File
- Resolves discrepancies between provider file and input data
- Forwards documents to appropriate DCC as directed by the system

Claims Adjudication

- Paraprofessional and professional staff adjudicate via PC using radiographs, scanned documents and attachments
- Forwards documents to appropriate DCC

System Batch Adjudication

- Updates nightly records and stores data processed from that day
- Transfers claim/TAR information into recipient's history file
- Collects payment data for weekly check run
- Generates reports
- Generates NOAs, RTDs, CIRs to provider

Document Control

- Stores processed document hard copies according to specific time frames
- Files and retains documents awaiting RTD response
- Maintains files
- Forwards x-ray envelopes to Recycle or Outgoing Mail for return to provider

Outgoing Mail

- Uses Phillipsburg equipment when appropriate to fold documents, stuff envelopes and affix postage
- Meters x-ray envelopes

Customer Support

- Communicates with providers via telephone and written correspondence
- Researches and responds to provider inquiries
- Handles provider enrollment and training

In administering the California Medi-Cal Dental Program, 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 the Medi-Cal Dental program to process documents as quickly and efficiently as possible. A description of the processing workflow is offered to promote a better understanding of the Medi-Cal Dental program automated claims system.

The TAR/Claim form and other related documents have been developed to simplify the billing process. An introductory packet of billing forms is mailed to all newly enrolled providers so they may begin participating in the Medi-Cal Dental program. All billing forms are available from the Medi-Cal Dental forms supplier at no charge to providers.

The Medi-Cal Dental Provider Handbook contains detailed, step-by-step instructions for completing each of the Medi-Cal Dental forms. The handbook also provides a handy checklist 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, the Medi-Cal Dental program 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
2. RTD
3. CIF
4. MC177
5. Written Correspondence
6. Enrollment Forms
7. Telephone Inquiry
8. NOA

B-PRL-TRN-005.AD

THE TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM FORM

The TAR/Claim form has been developed specifically for the Medi-Cal Dental program. Providers can use this form to request authorization of treatment under the Medi-Cal Dental program, or to submit for payment of completed, dated services. 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.

The dental office must accurately complete the form to insure proper and expeditious handling by the Medi-Cal Dental program. Forms that are incomplete or inaccurately filled out may cause delays in processing and/or requests for additional information. Please ensure the required information is typed or printed clearly. To submit the TAR/Claim form to the Medi-Cal Dental program, 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:

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

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO. CA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm / dd / yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address	00000	

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY? 3	YES X	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF	YES
		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE:	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.)	20. BILLING PROVIDER NPI
ADAMS, JAMES DDS	1234567891
21. MAILING ADDRESS	**TELEPHONE NUMBER**
30 CENTER STREET	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
ANYTOWN, CA	95814

BIC Issue Date: mm/dd/yy

EVC #: 123456789A1

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT -PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Exam	MM DD YY		D0150	25.00	9912345678
		2 4 Bitewings	MM DD YY		D0274	20.00	9912345678
		3 Additional PA's	MM DD YY	6	D0230	24.00	9912345678
8	MIF	4 Composite	MM DD YY		D2332	150.00	9912345678
5	MOD	5 Amalgam	MM DD YY		D2160	65.00	9912345678
16		6 Extraction	MM DD YY		D7140	125.00	9912345678
		7					
		8					
		9					
		10					

34. COMMENTS	35. TOTAL FEE CHARGED	409.00
	36. PATIENT SHARE-OF-COST AMOUNT	
	37. OTHER COVERAGE AMOUNT	
	38. DATE BILLED	MM DD YY

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

X _____ _____
SIGNATURE *DATE*

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

Example of a Facility Claim Form

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone 800-423-0507

TREATMENT AUTHORIZATION REQUEST (TAR) / CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	3. SEX (M / F)	4. PATIENT BIRTHDATE (MO / DAY / YR)	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm / dd / yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address (1)	00000	

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?_____	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
			YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. BILLING PROVIDER NPI
ADAMS, JENN DDS	1234567891
21. MAILING ADDRESS	**TELEPHONE NUMBER**
30 CENTER STREET	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
ANYTOWN, CA	95814

BIC Issue Date: mm/dd/yy

EVC #: 123456789A1

22. PLACE OF SERVICE (3)

OFFICE	HOME	CLINIC	SNF	ICF	IN-PATIENT	HOSPITAL OUTPATIENT	OTHER (PLEASE SPECIFY)
1	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH#/LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Prophy	MM DD YY		D1110	85.00	9912345678
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS (1) (2) (4)

35. TOTAL FEE CHARGED	85.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	MM DD YY

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS ROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

x Mary Smith — SIGNATURE

MM DD YY — DATE

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

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

1. Facility address
2. Facility name and facility phone number
3. Check box 4 or 5 only on the claim regardless of where the patient is being treated
4. If treating patients outside of the facility, indicate in box 34 where the patient is actually being treated, i.e., office, hospital

DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15610
SACRAMENTO, CA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST,FIRST,M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID NUMBER
Last, First	x	mm / dd / yy	99999999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
Address	00000	

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY? 9	YES X	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE:	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES X	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST,FIRST,M.I.)	20. BILLING PROVIDER NPI
Adams, James DDS	1234567891
21. MAILING ADDRESS	**TELEPHONE NUMBER**
30 Center Street	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
Anytown, CA	95814

BIC Issue Date: _____

EVC #: _____

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

EXAMINATION AND TREATMENT

26. TOOTH#/LTR. ARCH.QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
U		1 Partial Denture – Resin Base			D5211	400.00	
L		2 Partial Denture – Resin Base			D5212	400.00	
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS

All other treatment has been completed
See attached DC-054 form

35. TOTAL FEE CHARGED	800.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	MM DD YY

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

IMPORTANT NOTICE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

X Mary Smith
SIGNATURE

MM DD YY
DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

DC-217 (R 10/19)

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.

6. Use field 34 for any narrative documentation.

7. Continuous TAR/Claim forms and laser forms are not pre-imprinted by the Medi-Cal Dental program. Enter the provider's name, number and address exactly as it appears on your initial stock of forms.

8. If dated services are submitted on a request for authorization, they will not be paid until the authorized services are paid.

9. The Medi-Cal dental program will consider payment for dated services at 100% of the Schedule of Maximum Allowances (SMA) if the form is received within six months of the date of service. If the form is received within seven to nine months of the date of service, 75% of the of the SMA will be considered for payment. If the claim is received within ten to twelve months of the date of service, 50% of the SMA will be considered for payment.

10. REFER TO YOUR MEDI-CAL DENTAL PROVIDER HANDBOOK FOR MORE DETAILED INFORMATION ABOUT SUBMITTING THE TAR/CLAIM FORM.

THE NOTICE OF AUTHORIZATION (NOA) FORM

The NOA is a computer-generated form which the Medi-Cal Dental program sends to the provider following final processing of a TAR. The Medi-Cal Dental program will indicate on the NOA whether the requested services are allowed, modified, or disallowed. 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 the Medi-Cal Dental program 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 Medi-Cal Dental handbook)

The NOA received by the dental office is printed with the same information that was submitted on the original TAR. Please be sure to verify that the printed information is correct prior to completing the form and returning it to the Medi-Cal Dental program.

Authorizations are valid for 180 days. Once the services have been performed, complete the appropriate shaded areas on the NOA, sign and date, and submit one copy to the Medi-Cal Dental program for payment. Retain the other copy for the patient's record.

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

The Medi-Cal Dental program 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.

DO NOT WRITE IN THIS AREA

YY318100124

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/YY
TO: 05/13/YY

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

RE-EVALUATION IS REQUESTED ☐ YES

PAGE_____OF_____

1. MEMBER NAME (LAST, FRIST, M.I.)	3. SEX M / F	4. BENEFICIARY BIRTHDATE MO / DAY / YR	5. BENEFICIARY MEDI-CAL I.D. NO.
Last, First	X	mm / dd / yy	99999999999999

9. RADIOGRAPHS ATTACHED? CHECK IF YES / HOW MANY? _____	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED? YES	13. OTHER DENTAL COVERAGE? CHECK IF YES / 16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James, DDS 1234567891
30 Center Street (xxx) xxx-xxxx
Anytown, CA 95814

23. BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO OR LETTER ARCH	27. SUR-FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
	3		1 Root Canal Therapy	XXXXX		D3320	500.00	.00	R270	
	3		2 Root Canal Therapy			D3330	500.00	331.00	S270	
	3	O	3 Amalgam			D2140	55.00	39.00	355C	
	9		4 Extraction - Erupted Tooth			D7140	50.00	41.00	355C	
	U		5 Partial Denture – Resin Base		01	D5211	400.00	250.00		
	LL		6 Scaling & Root Planing	XXXXX		D4341	50.00	.00	081	
			7							
			8							
			9							
			10							
			11							
			12							
			13							
			14							
			15							

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- WHEN APPLICABLE ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA
- ADJUSTMENT CODES - SEE PROVIDER HANDBOOK
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO PATIENT ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	1555.00
46. TOTAL ALLOWANCE	661.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION
- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. TREATMENT COMPLETED – PAYMENT REQUESTED

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ ORIGINAL SIGNATURE REQUIRED _____ DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SIGN ONE COPY AND SEND IT TO DENTI-CAL – RETAIN THE OTHER FOR YOUR RECORDS.

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO MEMBER'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

REEVALUATION REQUEST

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

1. Check the box marked “REEVALUATION 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:

   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609

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

Re-evaluation

STAPLE HERE

DO NOT WRITE IN THIS AREA

YY318100124

STAPLE HERE

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO CALIFORNIA 95852-0609
Phone (800) 423-0507

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:
FROM: 11/14/YY
TO: 05/13/YY

RE-EVALUATION IS REQUESTED ☐ YES

PAGE ____ OF ____

1. MEMBER NAME (LAST, FIRST, M.I.): Last, First
3. SEX: X M F
4. MEMBER BIRTHDATE: MO mm | DAY dd | YR yy
5. MEMBER MEDI-CAL ID. NO.
9. RADIOGRAPHS ATTACHED — CHECK IF YES — HOW MANY? ____
10. OTHER ATTACHMENTS — CHECK IF YES
11. ACCIDENT/INJURY? EMPLOYMENT RELATED? — CHECK IF YES
13. OTHER DENTAL COVERAGE? — CHECK IF YES
16. CHDP — YES
7. MEMBER DENTAL RECORD NO.
23.
BIC Issue Date: _____
EVC #: _____

- Do Not sign NOA
- Do submit radiographs and new / additional documentation
- NOA must be received on or before the 'expiration date'
- NOA may only be resubmitted '1 time'

PRL-TRN-005.AD

NOA
HELPFUL HINTS/REMINDERS

1. Providers must wait until the NOA is received from the Medi-Cal Dental program before providing services that require prior authorization.

2. DO NOT attach a CIF when requesting a reevaluation.

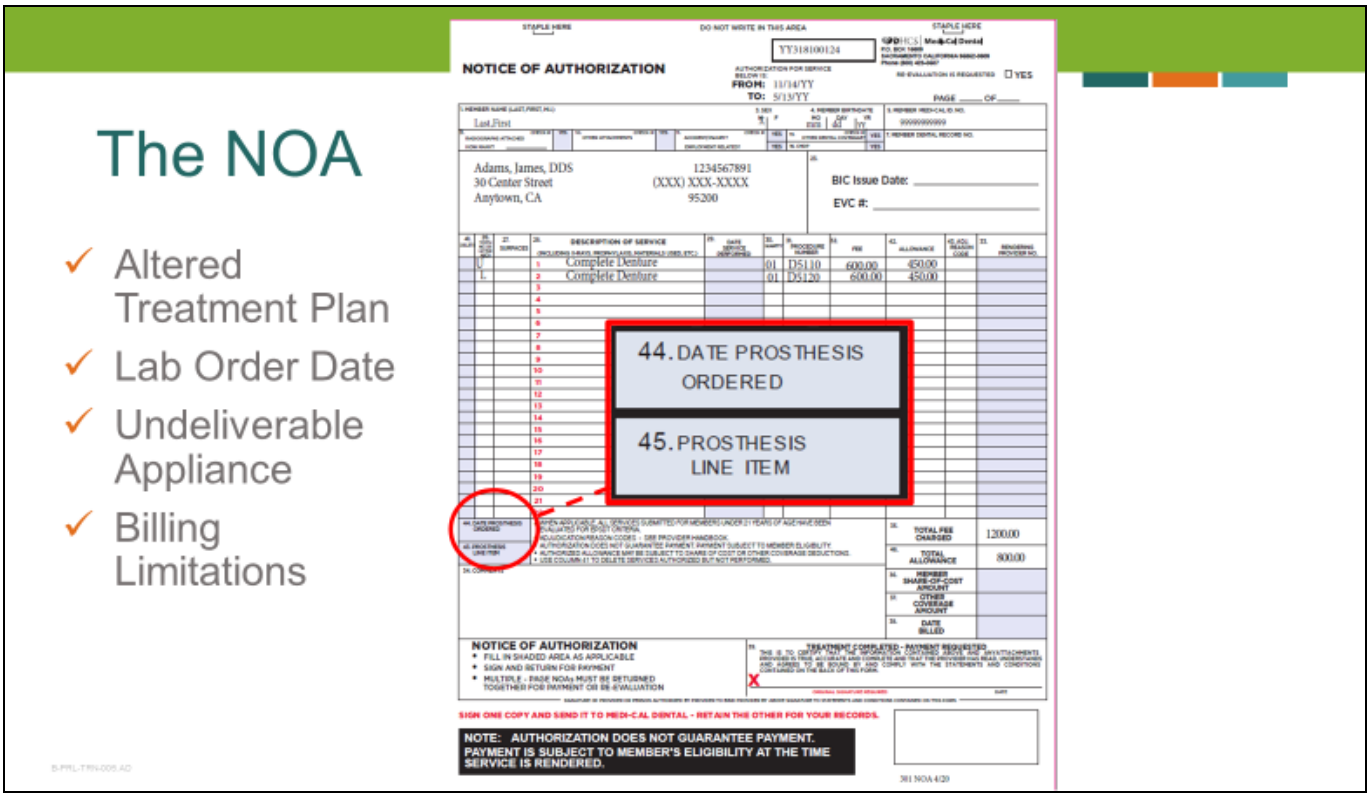
3. Return all upper pages of a multi-page NOA at the same time.

4. Include the rendering provider number in field 33 of the NOA.

5. Sign and date the NOA when submitting for payment.

6. REMINDER: Authorization does not guarantee payment. Payment is subject to a member's eligibility. More information can be found in Section 6: Forms of the Handbook

EXAMPLE OF NOA



RESUBMISSION TURNAROUND DOCUMENT (RTD)

The RTD is a computer-generated form sent to request missing or additional information needed to completely process the claim, TAR or NOA.

The RTD consists of two sections: Section “A” and Section “B”. The top portion “A” of the RTD indicates the associated DCN and lists the error(s) found on the original document. Section “A” also indicates the return due date. The provider has 45 days to respond to the RTD. Retain Section “A” for the office records. Section “B” indicates the associated DCN, lists the error(s) found on the original document and provides space to enter the requested information.

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

2. 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.

3. Return all pages of a multi-page RTD in one envelope.

4. Return the RTD promptly. If the RTD is not received by the Medi-Cal Dental program, within the 45-day time limitation, the Medi-Cal Dental program must deny the original claim, TAR or NOA.

5. Return the RTD to:

California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609

More information may be found in Section 6: Forms of the Handbook.

RESUBMISSION TURN AROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-06009
Phone 800423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO MEDI-CAL DENTAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDERHANDBOOK FOR FURTHER INFORMATION.

BILLING PROVIDER NAME / MAILING ADDRESS / CITY, STATE, ZIP CODE	MEDI-CAL PROVIDER NO.	NOTICE	PAGE OF PAGES
Adams, James, DDS 30 Center Street Anytown, CA 95814	1234567899		01 OF 01
		RTD ISSUE DATE: mm dd yy	RTD DUE DATE: mm dd yy

PATIENT NAME	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.
Last, First	99999999D			662.00	YY297102350

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		26	2		D7140	51	Procedure requires tooth code
B		39				52	Signature missing or invalid. Sign RTD.

A

RETAIN THIS PORTION

DETACH ALONG THIS PERFORATION

DOCUMENT CONTROL NUMBER * FOR MEDI-CAL DENTAL USE ONLY

DENTI-CAL USE ONLY

DCN	CLAIM TYPE	PAGE	PAGES
YY297102350	T	01 OF	01

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

BILLING PROVIDER NAME: Adams, James, DDS

MEDI-CAL PROVIDER NUMBER: 1234567899

PATIENT NAME: Last, First

PATIENT MEDI-CAL I.D. NUMBER: 99999999D

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
	26	04	51	A
	39		52	B

#14

This is to certify that the corrected information is true, accurate and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of the form.

X Mary Smith SIGNATURE — MM DD YY DATE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.

B

RETURN THIS PORTION TO: **MEDI-CAL DENTAL** P.O. BOX 15609, SACRAMENTO, CA 95852-0609

THE 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:

1. The member information: This line is preceded by an "B" for member information.
2. Claim information for the listed member: This line is preceded by a "C" for "Claim".
3. Provider Number: The National Provider Identifier (NPI) number that was issued by NPPES to a provider for their type of business.
4. Provider Name and Address: The provider's name and billing address.
5. Check Number: The number of the check issued with the EOB.
6. Date: The date the EOB was issued.
7. Page Number: The page number(s) of the EOB.
8. Status Code Definition: The list of each status code used to identify a claim line and explanation of what each code means.
9. Member Name: The name of the member; last name, first name and middle initial. Each member is listed individually.
10. 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).
11. Member ID: The member's ID number.
12. Sex: The sex of the member.
13. Birth Date: The member's date of birth.
14. Document Control Number: The identifying number assigned to each claim received by the Medi-Cal Dental program.

15. Tooth Code: The tooth number or letter, arch code or quadrant listed to help identify the procedure(s) reported on the EOB.

16. Procedure Code: The code listed on a claim line identifying each service performed. This code may differ from the procedure code submitted on the claim because of modification of the procedure by a Medi-Cal Dental professional or paraprofessional to comply with the criteria manual and successfully process the claim.

17. Date of Service: The date the service was performed.

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

19. Reason Code: Explains why a claim line was either denied, modified, altered or paid at an amount other than billed.

20. Amount Billed: The amount billed for each claim line.

21. Allowed Amount: The amount allowed by the Medi-Cal Dental program for each claim line. This amount is the lesser of the billed amount and maximum amount allowed by the SMA.

22. Share of Cost: The amount the member paid toward a Share of Cost.

23. Other Coverage: The amount paid by Medicare or any other insurance carrier.

24. Amount Paid: The total amount paid to a provider after any applicable deductions shown in item 22 and 23.

25. Claims Specific: The total amounts of all paid and adjusted claims listed on the EOB.

26. 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.

27. Check Amount: The amount of the check that accompanies the EOB.

More information may be found in Section 6: Forms, of the Handbook.

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

1 LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

2 LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

3 PROVIDER No 1234567899

4
Adams, James, DDS
30 Center Street
Anytown, CA 95814

5 CHECK No 00596352

6 DATE: 06/06/YY 7 PAGE NO. 3 of 3

8 STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B 9 MEMBER NAME 10 MEDI-CAL I.D. NO. 11 MEMBER ID 12 SEX 13 BIRTH DATE

C 14 DOCUMENT CONTROL NO. 15 TOOTH CODE 16 PROC. CODE 17 DATE OF SERVICE 18 STA-TUS 19 REASON CODE 20 AMOUNT BILLED 21 ALLOWED AMOUNT 22 SHARE OF COST 23 OTHER COVERAGE 24 AMOUNT PAID

ADJUDICATED CLAIMS

B	LAST	FIRST				99999999D		99999999D	M	mm/dd/yy
C	YY163108181	D0150	0601YY	P		25.00	25.00			25.00
C		D0274	0601YY	P		30.00	18.00			18.00
C		D0230	0601YY	P		30.00	18.00			18.00
C		D1120	0601YY	D	R019	47.00	.00			.00
C		D1110	0601YY	P	S019	47.00	40.00			40.00
	CLAIM TOTAL					132.00	101.00			101.00
	**TOTAL ADJUDICATED CLAIMS					132.00	101.00			101.00

ADJUSTMENT CLAIMS

B	LAST	FIRST				99999999D		99999999D	F	mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY168101357	15	D7210	0610YY	A	266B	- 95.00	- .00		- .00
C		14	D2140	0610YY	A		- 50.00	- 39.00		- 39.00
C		13	D2140	0610YY	A		- 50.00	- 39.00		- 39.00
	CLAIM TOTAL						- 195.00	- 78.00		- 78.00
B	LAST	FIRST				99999999D		99999999D	F	mm/dd/yy
C # 30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY168101357	15	D7210	0610YY	P		95.00	85.00		85.00
C		14	D2140	0610YY	P		50.00	39.00		39.00
C		13	D2140	0610YY	P		50.00	39.00		39.00
	CLAIM TOTAL						195.00	163.00		163.00
	*TOTAL ADJUSTED CLAIMS						00.00	85.00		85.00
	**PROVIDER CLAIMS TOTAL						132.00	186.00		186.00

25 CLAIMS SPECIFIC		26 NON CLAIMS SPECIFIC			27
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00				186.00

EXPLANATION OF BENEFITS

DHCS | Medi-Cal Dental

P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "R" CONTAIN MEMBER INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

PROVIDER
No 1234567899

CHECK
No 00596352

Adams, James, DDS
30 Center Street
Anytown, CA 95814

DATE: 06/06/YY PAGE NO. 3 of 3

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B MEMBER NAME | MEDI-CAL I.D. NO. | MEMBER ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

DOCUMENTS IN-PROCESS

LAST NAME	FIRST NAME	MEDI-CAL ID	MEMBER ID	DOB	DCN	AMT BILLED		*CODE
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY168108150	567.00	C	IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	YY169103850	423.00	T	CS
LAST	FIRST	99999999A	99999999A	mm/dd/yy	YY175100684	112.00	C	IR

TOTAL DOCUMENTSIN-PROCESS 3 TOTAL BILLED 1102.00

* THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR REEVALUATION

DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR XRAYS/ATTACHMENTS WAS SENT TO PROVIDER)
RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

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THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:30 AM TO 11:30 AM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

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THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

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THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN
ON MM/DD/YY FROM 8:30 AM TO 3:30 PM. PLEASE CALL (800) 423-0507
FOR RESERVATIONS

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

Provider Inquiries

Claim Inquiry Forms

THE CLAIM INQUIRY FORM (CIF)

Submitting a CIF enables the Medi-Cal Dental program 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) The Medi-Cal Dental program 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: Is used to request the status of a claim or TAR.

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 EOB, a CIF Tracer should be submitted.

CLAIM REEVALUATION: Is used to request the reevaluation of a modified or denied claim or NOA.

If a provider wishes to have a processed claim or NOA that has appeared on the EOB reevaluated, a CIF Reevaluation should be submitted. The CIF must be submitted within 6 months of the date on the EOB. DO NOT re-bill on a claim form.

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

1. Use a separate CIF for each inquiry.
2. Check only one inquiry reason box on each CIF.
3. Complete all applicable areas.
4. Sign and date.
5. Attach all related radiographs/photos.
6. DO NOT USE THE CIF TO REQUEST A FIRST LEVEL APPEAL.
7. Mail to:

California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0610

Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by telephone or written correspondence. Prior to submitting a CIF, please contact the telephone service center (TSC) at (800) 423-0507 with any inquiries.

All radiographs/photos submitted with a CIF must be stapled to the back of the corresponding CIF. More information may be found in Section 6: Forms of the Handbook.

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions

For clarification call DENTI-CAL

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James DDS	1234567899
MAILING ADDRESS: 30 Center Street	TELEPHONE NUMBER: (XXX) XXX-XXXX
CITY, STATE: Anytown, CA	ZIP CODE: 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI)	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)	
Last, First		
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
99999999999999		*MM DD YY*

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

- [X] Claim for Payment. Attach a copy of form Date of Service *MM DD YY*
- [ ] Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

- [ ] Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional information)

Please research claim for D.O.S. MM DD YY- we have no record of payment. Thank you

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X *Mary Jones* SIGNATURE — MM DD YY DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR DENTI-CAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

CORRESPONDENCE REFERENCE NUMBER * FOR MEDI-CAL DENTAL USE ONLY

YY30900132

CLAIM INQUIRY RESPONSE

Adams, James, DDS	1234567899
30 Center Street	(XXX) XXX-XXXX
Anytown, CA	95814

DHCS | Medi-Cal Dental
P.O.BOX 15609
SACRAMENTO, CALIFORNIA 95852
Phone (800) 423-0507

PATIENT NAME	DOCUMENT CONTROL NO.	
Last, First		
PATIENT MEDI-CAL I.D. NO.	PATIENT DENTAL RECORD NUMBER	DATE BILLED
99999999D		MM DD YY

IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY

STATUS CODE	EXPLANATION
01	CLAIM NEVER RECEIVED: PLEASE SUBMIT NEW CLAIM

ADDITIONAL EXPLANATION

BY: 7AW DATE: MM DD YY

RESPONSES TO CIF INQUIRIES

The Claim Inquiry Response (CIR) (Claim/TAR Tracer)

After resolving your CIF Tracer inquiry, The Medi-Cal Dental program will send your office a computer-generated CIR. The CIR explains the status of your claim or TAR. It contains the same information as the original document submitted by your office and will identify the patient's name, Medi-Cal ID number, dental record number (if applicable), DCN of the original document, and the date services were billed. The middle section of the form under the heading "In Response to your Medi-Cal Dental Inquiry" contains a status code and a printed explanation of the code.

The Explanation of Benefits (EOB) (Claim Reevaluation)

After processing your CIF for claim reevaluation, the response will be indicated on the EOB under "Adjustment Claims."

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call DENTI-CAL

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James DDS	1234567899
MAILING ADDRESS: 30 Center Street	TELEPHONE NUMBER: (XXX) XXX-XXXX
CITY, STATE: Anytown, CA	ZIP CODE: 95814

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, MI)	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)	
Last, First	*YY283101357*	
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED
99999999999999		

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

☐ Claim for Payment. Attach a copy of form Date of Service _____.

☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

☒ Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

REMARKS (Corrections or Additional information)

Please re-evaluate #15 procedure D7210 - X-ray attached (or submit digitized image reference number)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X *Mary Jones* _____ *mm dd yy*

SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR MEDI-CAL DENTAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 07/09)

Provider Appeals Process

First Level Appeals

THE PROVIDER APPEALS PROCESS

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

The First Level Appeal procedure is as follows:

1. The appeal must be submitted in writing to the Medi-Cal Dental program within 90 days of the action precipitating the complaint or grievance. Do not use a CIF for this purpose.
2. The letter must specifically indicate a request for a First Level Appeal.
3. The appeal must clearly identify the claim or TAR in question and describe the disputed action.
4. Keep a copy of all documents related to the appeal.
5. the Medi-Cal Dental program will acknowledge the appeal request with in 21 calendar days of receipt.
6. Direct first level appeals to:

   California Medi-Cal Dental Program
   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.

JUDICIAL REMEDY

A provider who is dissatisfied with the 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.

First Level Appeals

1. Submit within 90 days
2. Use letterhead not a CIF
3. Letter must specifically request a 1st Level Appeal
4. Send all information/copies to uphold the request
5. Send Appeals directly to the Appeals address
6. Office will receive written notification from the Medi-Cal Dental program within 21 days
7. Last recourse with the Medi-Cal Dental Program

EXPLANATION OF BENEFITS

LINES PRECEDED BY "B" CONTAIN MEMBER INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE MEMBER

DHCS | Medi-Cal Dental
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER No **1234567899**

CHECK No **00596352**

DATE: 06/06/YY PAGE NO. 1 of 3

Adams, James, DDS
30 Center Street
Anytown, CA 95814

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B	MEMBER NAME					MEDI-CAL I.D. NO.			MEMBER ID		SEX	BIRTH DATE	
C	DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED		ALLOWED AMOUNT	SHARE OF COST		OTHER COVERAGE	AMOUNT PAID

ADJUSTMENT CLAIMS

B	LAST	FIRST					99999999D		99999999D		F	mm/dd/yy	
C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED													
C	YY168101357	15	D7210	1010**YY**	A	266B	- 95.00		- .00				- .00
C		14	D2140	1010**YY**	A		- 50.00		- 39.00				- 39.00
C		13	D2140	1010**YY**	A		- 50.00		- 39.00				- 39.00
	CLAIM TOTAL						-195.00		- 78.00				- 78.00
B	LAST	FIRST					99999999D		99999999D		F	mm/dd/yy	
C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED													
C	YY168101357	15	D7210	1010**YY**	P		95.00		85.00				85.00
C		14	D2140	1010**YY**	P		50.00		39.00				39.00
C		13	D2140	1010**YY**	P		50.00		39.00				39.00
	CLAIM TOTAL						195.00		163.00				163.00
	*TOTAL ADJUSTED CLAIMS						.00		85.00				85.00
	**PROVIDER CLAIMS TOTAL						132.00		186.00				186.00

WHEN APPLICABLE, ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA.

266B PAYMENT AND/OR PRIOR AUTHORIZATION DISALLOWED. LACK OF RADIOGRAPHS

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	**85.00**				**186.00**

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.

CORRESPONDENCE REFERENCE NUMBER (CRN): An identifying number assigned to all telephone correspondence, written correspondence and CIF's received by the Medi Cal Dental program.

MEDI-CAL DENTAL: The Fee-for-Service portion of the California Medi-Cal Dental Program.

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

MEDI-CAL DENTAL PROVIDER HANDBOOK: A reference guide for all providers enrolled in the California Medi-Cal Dental Program. It contains the criteria for dental services, program benefits, exclusions, limitations, and instructions for completing forms used in the Medi-Cal Dental program. 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 the Medi Cal Dental program. The DCN enables the 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 the Medi-Cal Dental program. When the NOA is returned to the 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 the Medi-Cal Dental program 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.