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MEDI-CAL HAS DENTAL COVERED

Provider Bulletin

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THIS ISSUE

SIGN UP FOR OUR EMAIL LIST

Learn the latest Medi-Cal Dental news and information by signing up for our Medi-Cal Dental Fee-For-Service Provider email distribution list here.

TRAINING SEMINARS

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

Correction: New Dental Managed Care Billing Codes for FQHC/RHC Providers

The previously published DHCS article "Coming Soon: New Dental Managed Care Billing Codes for FQHC/ RHC Providers" announced a proposed, new HIPAA-compliant code combination for the Dental Managed Care (DMC) differential rate, effective July 1, 2024, for Sacramento, Los Angeles, and San Mateo counties. The implementation of this policy has been postponed.

At this time and until further notice, all Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers should continue to bill for Medi-Cal Managed Care member dental visits in a DMC plan as shown below:

Revenue Code	Dental Procedural Code	Modifier
0521	T1015	SE

Note: FQHC providers approved to participate in the Alternative Payment Methodology (APM) will receive separate communication announcing the APM DMC billing codes directly from the Department of Health Care Services (DHCS) Capitate Rates Development Division (CRDD). The Telephone Service Center (TSC) representatives are

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currently unable to assist with the FQHC APM billing policy, please direct questions to FQHCAPM@dhcs.ca.gov.

When dental services are provided to Medi-Cal Fee-For-Service members, or members not in a DMC, all FQHC/RHC providers should bill using Per Visit Code 03.

Medi-Cal providers must submit all claims with the specific Current Dental Terminology (CDT) code on the *UB-04* Informational Line. FQHC and RHC providers can only bill for one dental service per day. More than one visit may be counted in the same day, if after the first visit, the Medi-Cal member suffers illness or injury that requires another health diagnosis or treatment. If your FQHC/RHC has had claims denied, please resubmit them.

Claims submitted by FQHC and RHC providers using the new dental managed care billing codes for dates of service on after July 1, 2024, were denied with Remittance Advice Details (RAD) codes 9993, (The service code combination is not valid for the billing provider) or 0145, (This procedure is not a Medi-Cal benefit on this date of service). If your FQHC/RHC has had claims denied, please resubmit them as directed below.

Resubmitting Denied Claims

Claim corrections are required to reprocess these claim denials. As the dates of service are within six months following the month in which services were rendered, FQHC/RHC providers are instructed to correct impacted claims to reflect the current revenue code/procedure code/modifier combination and resubmit them as original claims. Corrected claims may be submitted hardcopy or electronically. The *Claims Inquiry Forms* (CIF) and *Appeal Form* 90-1 or *Electronic Claims Resubmissions/Voids*: 837I processes do not need to be utilized.

Additional Resources

See *Claim Submission and Timeliness Overview* (claim sub) in the Part 1 manual for more information.

Providers are encouraged to monitor the Medi-Cal Provider website for future updates. Questions regarding this notice may be directed to the TSC at 1-800-541-5555, Monday through Friday, except holidays.