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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.

# Use of D3221 vs Definitive RCT

Medi-Cal Dental would like to clarify for providers the difference between D3221 vs. Definitive Root Canal Therapy (RCT) procedure codes D3310, D3320, and D3330.

Procedure code D3221, also known as "open and med," is a benefit for permanent teeth and over-retained primary teeth with no successor. D3221 is an emergency procedure which does not require prior authorization and does not require submission of radiographs or documentation for payment. Radiographs, photographs, and/or written documentation demonstrating medical necessity is required to be in the chart notes. D3221 is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. It is to be used for patients where prior authorization for RCT has not yet been approved.

RCT does not require prior authorization for members under the age of 21. On the other hand, prior authorization for initial RCT is required for members aged 21 or older.

Example scenarios:

- A member is in acute pain but has not yet received prior authorization for RCT. The provider can perform D3221 to relieve pain until the RCT is approved; or,
- When a member in acute pain already has prior authorization for RCT, the provider may not bill for D3221 and should go ahead and perform the RCT.

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Reminder:

Arch Integrity Radiographs are required for prior authorization of RCT members aged 21 and over except for documented medical conditions such as pregnancy.

For questions and support, please contact the Medi-Cal Dental Telephone Service Center at (800) 423-0507 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

# Complaint or Grievance Process

Medi-Cal Dental would like to remind providers about the Medi-Cal Dental Member complaint or grievance process and its limitations. It is important to note that a Medi-Cal Dental member complaint or grievance is separate from a complaint or grievance filed with the State Dental Board. Complaints or grievances submitted to Medi-Cal Dental are not forwarded to the State Dental Board.

Members have the right to file a complaint or grievance for any reason, whether it's concerning scope of benefits, quality of care, modification or denial of a TAR/Claim form or other aspects of services provided under Medi-Cal Dental. Medi-Cal Dental will issue the provider a written notification indicating the specific reasons for the recoupment of previously paid services if services deemed to be inadequate.

When members file a complaint:

- Medi-Cal Dental will acknowledge the written complaint or grievance within three calendar days of receipt.
- The written complaint or grievance may be referred to a Medi-Cal dental consultant, who will determine the next course of action, which could include contacting the patient and/or provider, referring the patient to a clinical screening examination by a Medi-Cal Dental Clinical Screening Dentist, or referral to the appropriate peer review body.
- When a copy of the member's chart and other pertinent information is requested from a provider's office, it is important that this information be submitted to Medi-Cal Dental within the time frame indicated on the request to avoid potential recoupment of funds previously paid for the service(s) at issue.

For questions and support, please contact the Medi-Cal Dental Telephone Service Center (TSC) at (800) 423-0507 from 8:00 a.m. to 5:00 p.m., Monday through Friday.

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# Conlan Case Reimbursement Process

Medi-Cal Dental would like to remind providers about the Conlan reimbursement process. Conlan reimbursement forms may be submitted by members who paid out-of-pocket to a Medi-Cal Dental provider for covered services.

Providers will receive a notification in writing, if it is determined that the services provided by a Medi-Cal Dental provider qualify for reimbursement. The provider must reimburse the member directly to receive reimbursement for qualifying treatment performed.

Medi-Cal Dental will reimburse members directly if the provider has refused to reimburse for the qualifying treatment performed.

Medi-Cal Dental will directly reimburse members who received services and paid out-of-pocket expenses to providers who:

1. Are no longer in business
2. Do not produce enough revenue to properly reimburse member charges
3. Are not enrolled Medi-Cal Dental providers

For questions and support, please contact the Medi-Cal Dental Telephone Service Center (TSC) at (800) 423-0507 8:00 a.m. to 5:00 p.m. Monday through Friday.

# Enhanced Protections for Medi-Cal Members

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

Senate Bill 639, effective July 1, 2020, specifies in Business and Professions (B&P) Code, if a dental provider accepts Medi-Cal, the treatment plan for a Medi-Cal patient shall indicate

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if Medi-Cal would cover an alternate, medically necessary service as defined in current law, WIC Section 14059.5. The treatment plan shall indicate that the Medi-Cal patient has a right to ask for only services covered by Medi-Cal and that the dental provider agrees to follow Medi-Cal rules to secure Medi-Cal covered services before treatment.

Current Law:

- Dentists shall not arrange for or establish third-party credit or loans for patients administered or under the influence of general anesthesia, conscious sedation, or nitrous oxide. [B&P Code § 654.3(g)].

- Dentists shall not charge to third-party lines of credit (arranged for or established in their office) any treatment costs before the treatments are provided, unless the dentist provides the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs. [B&P Code § 654.3(b)].

The written treatment plan must include:

- Each anticipated service to be provided and the estimated cost of each service;

- The patient's private or government-estimated share of cost for each service (if applicable, including whether Medi-Cal will cover the service); and

- If services are not covered by patient's private or other insurance (including Medi-Cal), notification that the services may not be covered and that the patient has the right to confirm coverage before starting dental treatment.

- Written notice must be provided in patient's threshold language. [B&P Code § 654.3(f)].

All of the current requirements above continue to apply, with the following additions:

- Dentists shall not charge to third-party lines of credit (arranged for or established in their office) any treatment costs more than 30 days before the treatments are rendered (except for orthodontia). [B&P Code § 654.3(c)]

- Dentists shall not arrange for or establish an open-end credit or loan that contains a deferred interest provision (which is common under many current third-party credit companies). [B&P Code § 654.3(b)]

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- Dentists are prohibited from completing any part of a third-party credit or loan application on behalf on the patient. [B&P Code § 654.3(e)].

- Dentists shall provide the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs.

  - The notice must include the revised language specified in B&P Code § 654.3(g).

  - For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment. [B&P Code § 654.3(h)(1)].

- Dentists shall not arrange for or establish third-party credit or loans when patients are in a treatment area (including but not limited to exam rooms, surgical rooms, and any other area where dental treatment is provided) unless the patient agrees to do so. [B&P Code § 654.3(j)].

For more information about Medi-Cal billing practices and references to the B&P Codes referenced in the article, please refer to the Provider Handbook Section 2 — Program Overview.

For more information, please call the Telephone Service Center (TSC) at (800) 423-0507, available from 8:00 a.m. to 5:00 p.m. Monday through Friday.