California
Medi-Cal Dental

Workshop Packet

Revised 05/09/24

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

Dear Medi-Cal Dental Provider and Staff:

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

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

Medi-Cal Dental
P.O. Box 15609
Sacramento, CA 95852-0609
Phone (800) 423-0507 | www.dental.dhcs.ca.gov

State of California
Gavin Newsom, Governor

California Health and Human Services Agency

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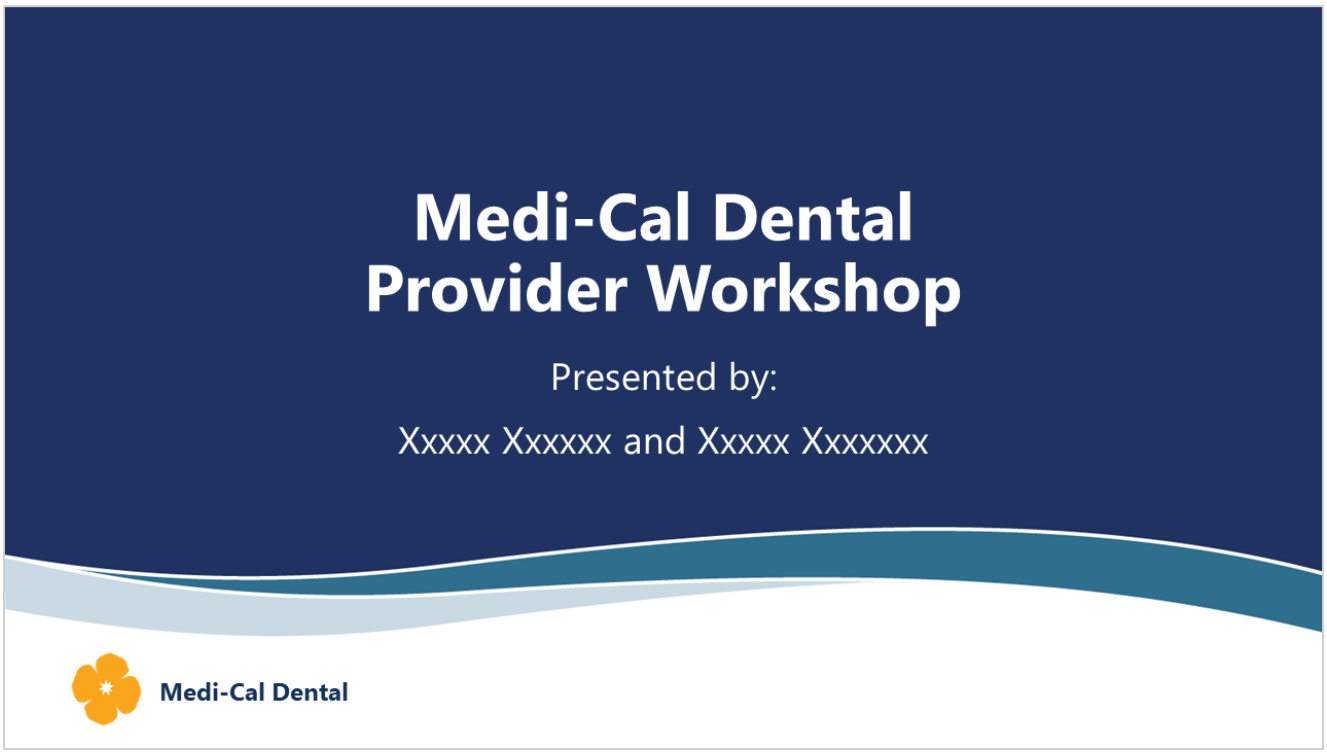
Introduction

This packet contains the information discussed in today's workshop regarding basic billing procedures, the use of forms, and program criteria. Please refer to the Medi-Cal Dental 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 workshop packet contains a glossary listing some of the terms mentioned in today's workshop.



Program Overview

The primary objective of Medi-Cal Dental is to create a better dental care system and increase the quality of services available to those individuals and families who rely on public assistance to help meet their health care needs. Through expanding participation by the dental community and efficient, cost-effective administration of Medi-Cal Dental, the goal to provide quality dental care to Medi-Cal members continues to be achieved.

Program Background

» The Medi-Cal Dental Program is governed by policies subject to the laws and regulations of the:

- Welfare and Institutions (W&I) Code
- California Code of Regulations (CCR), Title 22
- California Business and Professions Code – Dental Practice Act

Gainwell Technologies

» Administers:

- *Fee-For-Service* portion of the Medi-Cal Dental program for the Department of Health Care Services (DHCS)

» Provides:

- Customer service
- Treatment Authorization Request (TAR) and Claim processing
- Distribution of checks
- Distribution of the Explanation of Benefits (EOB)
- Enforcement of the rules and guidelines set by DHCS

Requirements for Providers

- Medi-Cal providers must ensure that all their rendering providers are enrolled in the Medi-Cal Dental program prior to treating Medi-Cal Dental members
  - Rendering providers must be associated to the service office location
- Payments made to Medi-Cal providers for services performed by their unenrolled rendering providers will be subject to payment recovery

See the Provider Handbook Section 3 (Enrollment Requirements) for more information.

National Provider Identifier (NPI) Numbers

- Obtain NPI numbers from National Plan and Provider Enumeration System (NPPES website) https://nppes.cms.hhs.gov/#/
  - Type 1: Health Care Providers who are individuals, including dentists and hygienists, and sole proprietorships, regardless of multiple service office locations
  - Type 2: Health Care Providers who are organizations, including dental practices, and/or individual dental practices who are incorporated
- Dental offices many need both Type 1 and Type 2 NPI numbers:
  - An individual dentist at one practice location where a Type 1 is needed for the dentist and a Type 2 for the practice if claims are submitted using the practice's name and Tax Identification Numbers (TINs)
  - Multiple dentists at one practice location where a Type 1 is needed for each dentist and a Type 2 for the practice if claims are submitted using the practice's name & TIN

Registered Dental Hygienists in Alternative Practice (RDHAP)

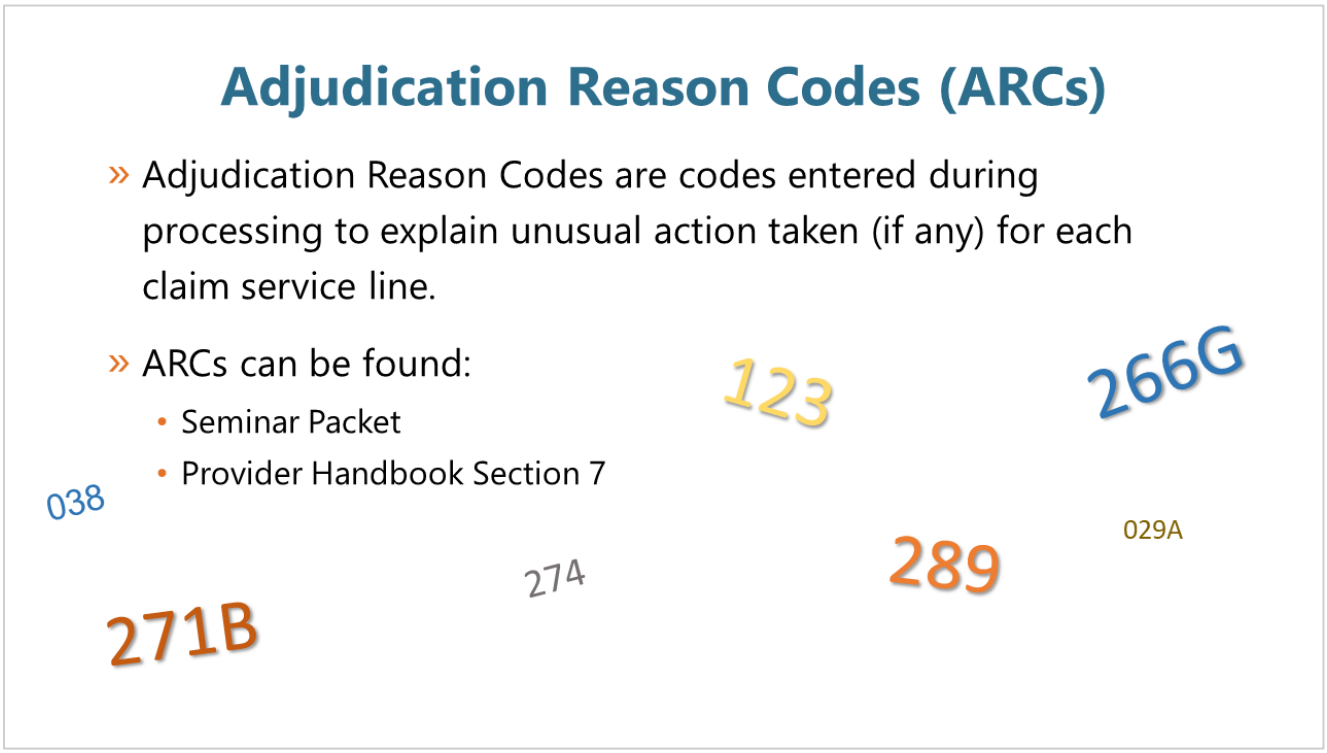
- Valid RDHAP procedure codes:
  - D0210, D0220, D0230, D0270, D0272, D0274, D0350, D1110, D1120, D1206, D1208, D1310, D1320 D1351, D1352, D1354, D2940, D2941 D4341, D4342, D4355 (SNF/ICF Only), D4910, D9410, D9920
  - CalAIM Caries Risk Assessment (CRA) bundle D0601, D0602, or D0603 with Nutritional Counseling D1310
- RDHAP may bill for radiographs taken in a teledentistry visit even if the exam and teledentistry codes will be billed by a dentist

See the Provider Handbook Section 5 (Manual of Criteria) for more information.

Program Criteria

- The Manual of Criteria is put forth by the Department of Health Care Services (DHCS) and establishes the criteria for the procedures
  - The criteria apply to all providers and members in the Program
  - The Program does make some modifications to the submission requirements

See the Provider Handbook Section 5 (Manual of Criteria) for more information.



Record Keeping Criteria for the Medi-Cal Dental Program

Medi-Cal Dental's Compliance Management/Surveillance and Utilization Review (CM/SUR) department monitors for suspected fraud, abuse, and poor quality of care. In overseeing appropriate utilization in the program, the CM/SUR department helps Medi-Cal Dental meet its ongoing commitment to improving the quality of dental care for Medi-Cal members.

The goal of the CM/SUR department is to ensure that providers and members are in compliance with the criteria and regulations of Medi-Cal Dental. To achieve this goal, the CM/SUR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. Furthermore, department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard, and/or unnecessary treatment. Refer to the Provider Handbook Section 8 (Fraud) for more information.

Title 22, California Code of Regulations (CCR), established record keeping criteria for all Medi-Cal Dental providers:

Record Keeping Criteria for the Medi-Cal Dental Program

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

See the California Code of Regulations, Title 22 for more information.

Record Keeping Criteria

- Medi-Cal Dental Program submission requirements may differ from the requirements of the Dental Practice Act or the Standard of Care for:
  - Prior authorization
  - Payment purposes

Upcoding

- Upcoding means billing for more surfaces than were actually restored or for billing for more complex procedures than were performed
- Provider Bulletin Volume 33, Number 2 (February 2017) reminds providers to avoid upcoding

See the Provider Handbook Section 8 (Fraud, Abuse, and Quality of Care) for more information.

Senate Bill 639

- Enhanced protections for Medi-Cal members
- Contains provisions regarding lines of credit between a provider and member
- Written treatment plan requirement:
  - Must indicate if Medi-Cal would cover an alternate medically necessary service
  - Must notify the Medi-Cal member that they have the right to ask for only services covered by Medi-Cal
  - The dentist must follow Medi-Cal rules to secure Medi-Cal covered services before treatment is rendered

See Bulletin Volume 36, Number 4 (March 2020) for more information.

Additional Services Offered by Medi-Cal Dental

Free Services Offered

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

American Sign Language (ASL) and Language Services

- **ASL assistance** – available via telephone during or scheduled in advance for the appointment
- **Language interpreters** – available in 250 languages and dialects via telephone
- **Free language tagline signs** – available for providers / members with limited English

All providers and members can request these free ASL translation and language services and other assistance by calling the Customer Service Center

www.smilecalifornia.org/partners-and-providers/#provider_office_language_assistance_sign

Language Assistance Services

- Mon-Fri 8am-5pm
- Provider requesting a translator for a member call **800-423-0507**
- Member requesting a translator call **800-322-6384**
- Members with hearing or speaking limitations call:
  - Teletext Typewriter (TTY) line at **800-735-2922**
- At all other times members call the California Relay Service TDD/TTY at **711** to receive the help they need

See the Provider Handbook Section 4 (Treating Members) for more information.

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

Note:

- *Members may call the P.O.S./Internet help Desk to remove other health care coverage.*
- *Members may call the Health Care Options number to change managed care*.

Customer Service Inquiries

Provider Toll Free Telephone Number

For information or inquiries, providers may call the Customer Service Center toll-free at (800) 423-0507. Providers are reminded to have the appropriate information ready when calling, such as:

1. Member Name
2. Member Medi-Cal Identification Number
3. Billing Provider Name
4. Provider Number
5. Type of Treatment
6. Amount of Claim or TAR
7. Date Billed
8. Document Control Number
9. Check Number

Customer Service Center Agents are available Monday through Friday between 8:00 a.m. and 5:00 p.m., excluding holidays. Providers are advised to call between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m., when calls are at their lowest level.

Inquiries that cannot be answered immediately will be routed to a customer inquiry specialist. The question will be answered by mail within 10 days of the receipt of the original telephone call.

Member Toll-Free Telephone Number

If an office receives inquiries from members, please refer them to the Customer Service Center toll-free member number at (800) 322-6384. The member lines are available from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding holidays.

Either members or their authorized representatives may use this toll-free number. Member representatives must have the member’s name, BIC or CIN, and a signed Release of Information form on file with Medi-Cal Dental in order to receive information from Medi-Cal Dental.

The following services are available from Medi-Cal Dental by Member Services toll-free telephone operators:

1. A referral service to dentists who accept new Medi-Cal dental members
2. Assistance with scheduling and rescheduling Clinical Screening appointments
3. Information about Share of Cost (SOC) and copayment requirements of Medi-Cal Dental
4. General inquiries
5. Complaints and grievances
6. Information about denied, modified, or deferred Treatment Authorization Requests (TARs)

Interactive Voice Response System (IVR) - Gabby

The Medi-Cal Dental IVR, referred to as Gabby, is an automated inquiry system for use by providers. Providers can access Gabby by dialing the toll-free information line (800) 423-0507 from a touch tone telephone. Gabby 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 the customer service center 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 their 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. A provider must be enrolled with Medicare to bill Medi-Cal Dental for Medicare/Medi-Cal crossover services.
2. Medicare must be billed for Medicare covered services prior to billing Medi-Cal Dental. When billing Medi-Cal Dental, attach the EOMB to the claim form.
3. Approved and paid Medicare dental services do not require prior authorization by Medi-Cal Dental.
4. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a member has no direct bearing on the coverage or exclusion of any given dental procedure.

Hospital Cases

When dental services are provided in an acute care general hospital or a surgicenter, the provider must 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 Medi-Cal Dental. Prior authorization is required only for the following services in a hospital setting: fixed partial dentures, removable prosthetics, and implants. It is not necessary to request prior authorization for services that do not ordinarily require authorization from Medi-Cal Dental, even if the services are provided in an outpatient hospital setting. In all cases, an operating room report, or hospital discharge summary must be submitted with the 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 member receives their medical services. Members may receive medical services 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 the Provider Handbook Section 4 (Treating Members) for instructions on how to determine the entity providing a member's 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 member 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

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

A 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 member's medical plan to arrange for hospital or surgical enter 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 Medi-Cal Form 50-1 for a Medi-Cal member who receives their medical benefits through one of these programs, the form will be returned to the submitting dentist.

Mobile Dental Treatment Vans

Mobile dental treatment vans are considered, under Medi-Cal Dental, to be an extension of the provider's office and are subject to all applicable requirements of the program.

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. To see to the codes, refer to the Provider Handbook Section 5 (Manual of Criteria and Schedule of maximum Allowances).

Orthodontic Services Program

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. Refer to the Provider Handbook Section 9 (Special Programs) 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. Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation.

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.

CCS 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. Refer to the Provider Handbook Section 9 (Special Programs) for more information.

CCS/Medi-Cal Authorizations and Claims Processing

Members with CCS/Medi-Cal eligibility do not require a CCS SAR. These members have full scope Medi-Cal eligibility and are only case managed by CCS. No CCS SAR request should be submitted.

CCS/Medi-Cal claims and TARs are to be sent directly to Medi-Cal Dental. Providers may submit a TAR requesting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for a Medi-Cal member requiring dental benefits beyond the scope of the Medi-Cal Dental 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 Medi-Cal Dental.

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 Field Representatives are available for onsite 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 onsite training visit. To request a visit please contact the Customer 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 to make a reservation.

Case Management

Dental Case Management is available for those members who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers. Case management services are intended for members with significant medical, physical, and/or behavioral diagnosis. Referrals for case management services are initiated by the member's medical provider, dental provider, case worker or healthcare professional 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. If you have questions when submitting an online referral, please contact the Customer Service Center at (800) 423-0507. Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Care Coordination Services

Care Coordination services are offered by the Customer Service Center (CSC). Care Coordination Services allow Medi-Cal members to call and gain access to dental services with the direction and support of our CSC agents, 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 Customer Service Center at (800) 322-6384, and request Care Coordination assistance.

Member Term Descriptions

Child

- Member under the age of 21(0-20)
- Scope of benefits based on aid code

Adult

- Member aged 21 and older
- Scope of benefits based on aid code
- For treatment that requires prior authorization, the Notice of Authorization (NOA) remains valid for members who reach their 21st birthday during the authorization period

Facility Resident

- Dental services for members who reside in a
  - SNF – Licensed Skilled Nursing Facility
  - ICF – Licensed Intermediate Care Facility
- Dental services do not have to be provided in the facility to be payable for Place of Service (POS) 4 or 5 residents

Pregnant Members

Members who are pregnant and up to 12 months of postpartum:

- Pregnant members regardless of age, aid code, and/or scope of benefits are eligible to receive all procedures listed in the Manual of Criteria as long as all procedure requirements and criteria are met
- Prior authorization is waived for D4341/D4342 (Scaling and Root Planing)
- All radiographic requirements must be met except:
  - Bitewing requirements are waived for D4341/D4342
    - (Covered in Periodontics section of seminar)
  - Arch integrity radiographic requirements waived

Pregnant Members

- You must document member's pregnancy or postpartum status on each document
- For all procedures that require radiographs, no payment will be made if the radiographs are not submitted. "Member refused x-rays" will not be acceptable documentation for non-submission of radiographs
- California Dental Association (CDA) www.cda.org/education

Program Criteria

Criteria Covered Today

- Emergency Services
- Diagnostic Services
- Preventive Procedures
- Restorative Procedures
- Crown
- Prefabricated Crowns
- Endodontics
- Periodontics
- Removable Prosthodontics
- Extractions
- Anesthesia
- Case Management
- EPSDT

CDT-23

- For TARs or Claims processed with Date of Service on or after April 1, 2023, there are two new procedure codes added as a benefit:
  - D6105: Removal of implant body not requiring bone removal nor flap elevation
  - D7251: Coronectomy - intentional partial tooth removal, impacted teeth only

Emergency Services

Emergency Services for Limited Scope Aid Codes

- Some members have Emergency Services Only Aid Codes
  - These cover specific emergency procedures, regardless of age
- If a member has one of these aid codes, the only procedures allowed are those listed in the Provider Handbook Section 4

See the Provider Handbook Section 4 (Treating Members) for more information.

D9110

Palliative Emergency Treatment of Dental Pain

- "Hands-On" emergency visit
- Payable once per date of service
  - Not per procedure or per tooth
- Requires documentation
- D0171 can only be billed as D9110 or D9430 and is not payable separately

Documentation

» For emergency procedures and members with Emergency Only Aid Codes, documentation shall include:

1. Chief Complaint
2. Diagnosis with tooth number or area
3. The treatment performed

Emergency Documentation

» Emergency Certification Statement signed by the treating dentist is required for members with aid codes for emergency services only

- Paper claims – use Comments Box 34
- EDI Claims – signature requirement waived though documentation must still be present

D9995 Teledentistry

Teledentistry – Synchronous; Real-time encounter

» Written documentation for payment shall include the number of minutes that the transmission occurred.

» Payable once per date of service per patient, per provider up to a maximum of 90 minutes at $.24/minute.

» Bill number of minutes in the Quantity field on your claim

» Do not bill D0999 or D9999 for Teledentistry

D9430 - Criteria

Office Visit for Observation – No Other Services Performed

- A benefit once per member, per date of service, per billing provider
- Not a benefit when rendered in a facility (SNF/ICF)
  - Use D9410 in facility

D9430

- "Hands-Off" visit
- Observation visit only that may include prescribing, reappointing, referral to specialist, etc.
- No documentation required for payment purposes, but documentation must be in member record according to Medi-Cal Dental Program guidelines

D9430

- D9430 should be billed for urgent or emergent appointments where your patient has a new concern
- It should not be billed for routine follow-ups, denture adjustments, denture progress visits, buildups, crown preparation appointments, suture removal, etc., nor as a routine "appointment fee"
- It should generally not be billed in the context of a normally scheduled appointment, nor used as a substitute code to request reimbursement when the procedure documented in the patient record is not payable

Teledentistry and D9430

- D9430 can be used for live streaming video or telephone with a Medi-Cal patient with oral health issues in lieu of an in-person office visit when billed with D9995

Teledentistry and D9430

- D9430 as part of teledentistry is only allowable for a conversation between the Medi-Cal member and the Medi-Cal provider about oral health issues as their chief complaint
- CDT code D9430 should not be billed for conversations with office staff about scheduling or rescheduling appointments

Recementation

- D2910 Inlay
- D2920 Crown
- D6930 FPD

- Benefit once in 12 Months without radiographs or documentation
- Additional Requests within 12 months require documentation

D2940

Protective Restoration

- For use as a temporary restoration
  - Requires tooth number
  - Benefit once per tooth per lifetime
  - Requires pre-op radiograph for payment
  - Not a benefit for RCT-treated tooth (use D9110)
  - Not a benefit on the same day as a definitive restoration in the same tooth

D2941

Interim Therapeutic Restoration – Primary Dentition

- Requires tooth number – Primary tooth only
- Benefit once per tooth in a six-month period per provider as a temporary restoration
- Requires pre-op radiograph for payment
- Not a benefit on the same day as a definitive restoration in the same tooth
- Not a benefit for a tooth which has had a pulpotomy
- Not a benefit as a base or liner under a restoration

D3221

Pulpal Debridement

- Benefit for initial Open & Drain – for the relief of acute pain prior to conventional root canal therapy
- No prior authorization
- No documentation or radiograph required for payment
- For permanent teeth or over-retained primary teeth with no successor
- A benefit once per tooth
- Not for root canal therapy visits once RCT has been authorized
- For additional emergency visits use D9110

D7510

Incision and Drainage of Abscess, Intraoral Soft Tissue

- Requires written documentation of condition, specific tooth or area, rationale for treatment and any pertinent history
- Benefit once per quadrant per date of service
- Not a benefit with other treatment in the same quadrant on the same date of service except for radiographs
- Fee includes the incision and placement and removal of any surgical draining device

D9910

Application of Desensitizing Medicament

- Requires Documentation
  - Tooth or teeth treated
  - Specific treatment provided
- A benefit once per date of service
- Permanent teeth only
- Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose the emergency condition
- This procedure is considered an emergency treatment only

D9440

Office Visit After Regularly Scheduled Hours

- Documentation required
  - Use the formula for emergency visits
  - Time and day of week required (ARC 267i)
- A benefit to compensate the provider for travel time outside of normal office hours
- A benefit once per member per date of service per provider

Diagnostic Services

D0145

Oral Evaluation for a Member Under Age 3 and Counseling with Primary Caregiver

- A benefit under the age of 3
  - D0150 or D0120 not a benefit under age 3
- A benefit once every three months per billing provider
- This is the only billable examination code for members under age 3

D0150

Comprehensive Oral Evaluation

- A benefit once per member per billing provider for initial evaluation for members age 3 and older
- Additional D0150 allowable if no D0120 or D0150 paid to same billing provider within previous 36 months

D0120

Periodic Oral Evaluation

- A benefit once every 6 months per billing provider for members age 3 through 20
  - At least 6 months after D0150 by same billing provider
- A benefit once every 12 months per billing provider for members age 21 and older
  - At least 12 months after D0150 by same billing provider

D0210

Radiographs – Complete Series (Including Bitewings)

- Not a benefit under age 11
  - Bill individual radiographs
- Complete series shall be at least one of the following combinations
  - 10 periapicals and bitewings
  - 8 periapicals, 2 occlusals, and bitewings
  - Pano, bitewings, and a minimum of 2 periapicals

D0210

- A benefit once in a 36-month period per billing provider
- Not payable when bitewings have been paid within 6 months to the same provider

D0220 D0230

Periapical 1st Film, Periapical Each Additional Film

- Submission of radiographs not required for payment
- Benefit to a maximum of 20 periapicals in a 12-month period
- Periapicals taken as part of FMX are not considered against this 20-radiograph limit

D0272 D0274

Bitewings

- 2 Films D0272
- 4 Films D0274

» A benefit once every 6 months per billing provider

» Not a benefit within 6 months of complete series D0210

» D0274 not a benefit under age 10

D0330

Panoramic Film

» A benefit once in a 36-month period per member per billing provider

Radiograph and Photograph Currency

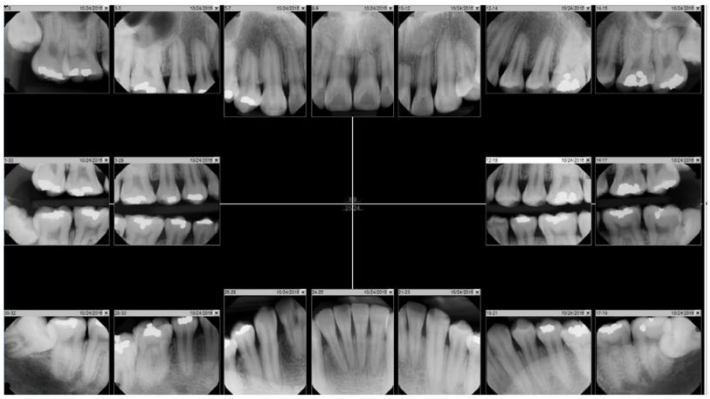
» What is a current photo or radiograph?

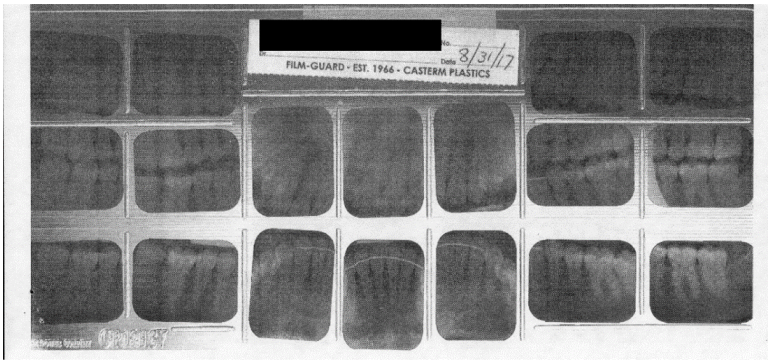
- Primary tooth – 8 months
- Permanent tooth – 14 months
- Arch integrity – 36 months

Radiograph and Photograph Submission

- Must be dated and current
- Must include member name
- Must include orientation – indicate tooth number, Left/Right, or quadrant/area as needed
- Must be of diagnostic quality

- Duplication and radiographic technique must be of diagnostic quality





D0350 - Photographs

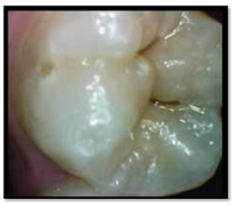
- Photographs must be appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs in order to be payable
- Not a benefit when used for member identification
- Recommended to supplement radiographs when the radiographs do not demonstrate medical necessity

D0350 - Photographs

- Submit photos with the procedure they support
- Maximum of 4 photos payable per date of service
- Additional photos may be submitted to demonstrate medical necessity

- Date on submitted photo must match the date of service on the claim form for the photo being billed
- Date of Service for photo does not need to be the date of service of the restoration

04-15-21 Name #14



EXAMINATION AND TREATMENT

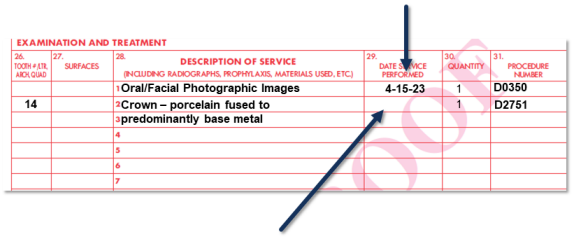
26. TOOTH # (1-32, A-T, MIX QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE OF SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER
		1 Oral/Facial Photographic Images	4-15-21	1	D0350
14	OL	2 Resin Base Composite - two	4-30-21	1	D2392
		3 surfaces, posterior			
		4			
		5			
		6			
		7			

Photos on TARs

- A TAR is any document where at least one Claim Service Line has no Date of Service entered
- We cannot prior authorize photos (ARC 031A)
- How does a provider get paid for a photo that supports a TAR?

Photos on TARs

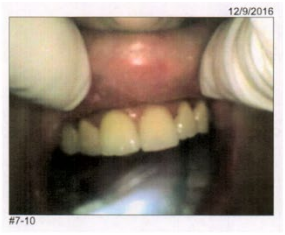
- Any photo must be submitted with a Date of Service to be payable
- Because this crown does not have a Date of Service, this document is a TAR
- Submit NOA for payment of the photo even if crown is not authorized
- If the crown is authorized, do not submit NOA until all treatment on the NOA is complete



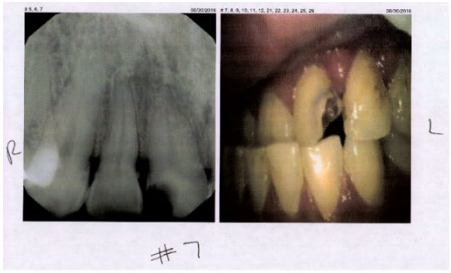
EXAMINATION AND TREATMENT

26. TOOTH # (1-32, A-T, QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER
		1 Oral/Facial Photographic Images	4-15-23	1	D0350
14		2 Crown – porcelain fused to		1	D2751
		3 predominantly base metal			
		4			
		5			
		6			
		7			

Radiograph and Photograph Submission



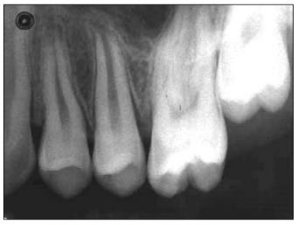
- Insufficient orientation
  - Image could be "reversed" vs. expectation
  - Better to point to which is #7



- Opposite orientation on photo and radiograph

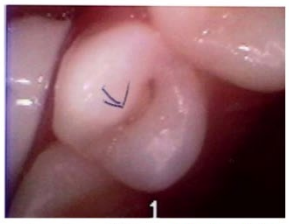
Undated Photos

- Undated photos receive ARC 029A and cannot be used for adjudication



First Last #12 6/11/21

Claim for Occlusal Restoration #12; caries not evident on radiograph

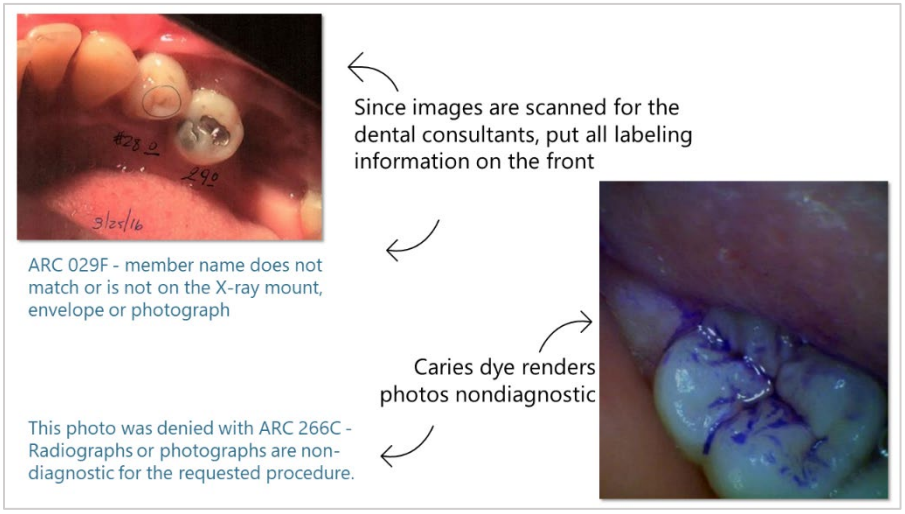


First Last #12 missing date

A photo that has no date cannot be used by a consultant

Radiograph/Photograph Tips

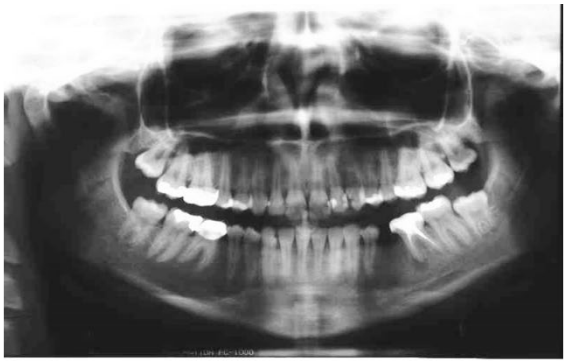
- The Medi-Cal Dental Program no longer returns radiographs or photos
- Submit only duplicates – never send your last film to us
- Dental consultants no longer handle physical radiographs, only scans, so duplication must be of high quality to be diagnostic
- Ensure high quality output if printing images



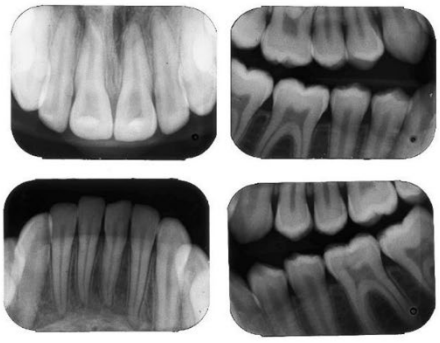
Arch Integrity

- Arch integrity and overall condition of the mouth, including the member's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5-year prognosis for the teeth or abutments
- Anterior periapical radiographs and bite-wings are enough to establish arch integrity of the arches
- Arch integrity radiographs are not the same as an FMX
- If arch integrity radiographs are not submitted the treatment will be denied

Arch Integrity

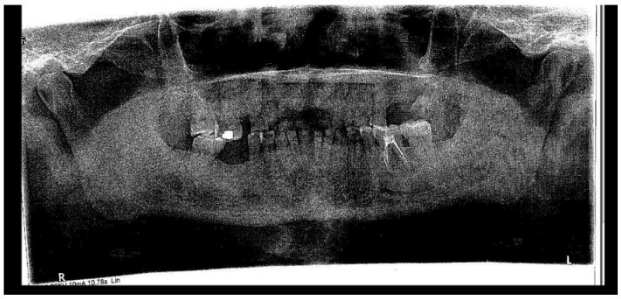


Arch Integrity



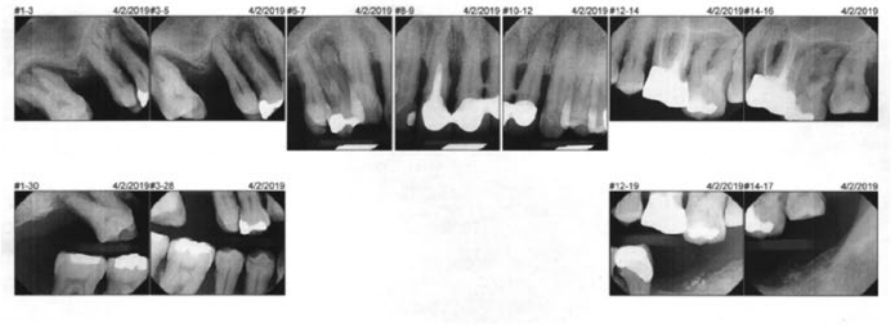
» Arch integrity is established in this case without an entire FMX

Arch Integrity



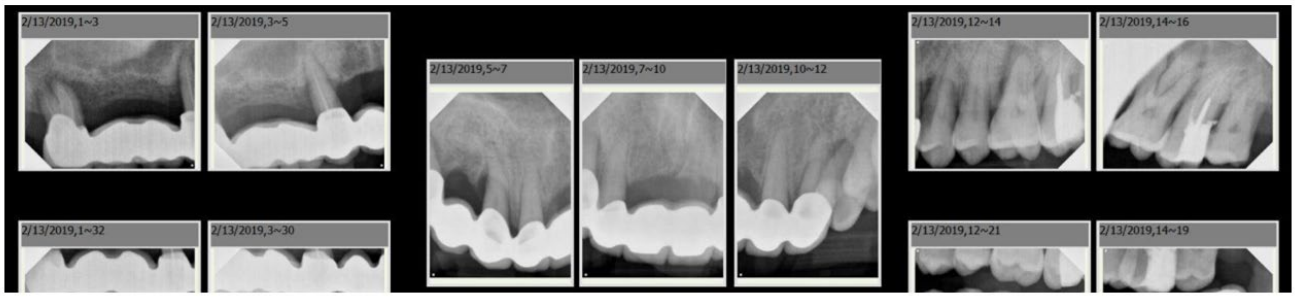
» 266H – Radiographs submitted to establish arch integrity are non-diagnostic

Arch Integrity



» 271C – Arch lacks integrity

Arch Integrity



» 271C – Arch lacks integrity

Preventive Procedures

Child – Under Age 6

- Prophylaxis D1120 a benefit once in a six-month period per member without prior authorization
- Fluoride D1206 or D1208 a benefit once in a four-month period

Child – Age 6 Through 20

- Prophylaxis D1120 and Fluoride D1206 or D1208 a benefit once in a six-month period

Adult

- Prophylaxis D1110
- Fluoride D1206 or D1208
- A benefit once in a 12-month period per member without prior authorization
- Note that prophylaxis and scaling & root planing procedure frequencies are per member, not per billing provider

SNF - ICF

- Prophylaxis (D1110 or D1120) and fluoride (D1206 or D1208) are a benefit once in a four-month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility

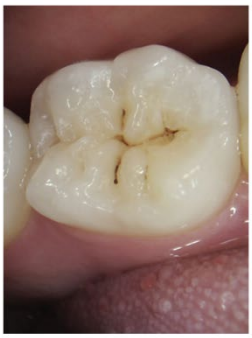
D1351 - Sealant

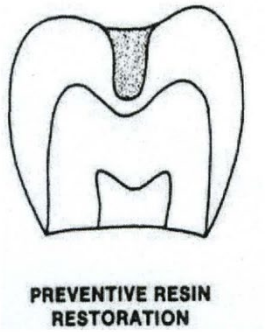
- Benefit under age 21 for 1st and 2nd permanent molars
- No prior authorization, radiographs, or documentation
- On claim form, indicate tooth number and surface(s) being sealed
- Occlusal surface must be sealed, must be caries free, and must be restoration free
- Original provider responsible for replacement for 36 months

D1352 – Preventive Resin

- Benefit under age 21 for 1st and 2nd permanent molars
- No prior authorization, radiographs, or documentation
- Only for active carious lesion in a pit or fissure that does not cross the DEJ
- Original provider responsible for replacement for 36 months

D1352





D1354 – Caries Arresting Medicament – Per Tooth

- Requires a tooth code
- A benefit for all ages
  - 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

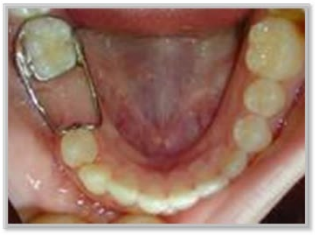
D1320- Tobacco Counseling for the Control and Prevention of Oral Disease

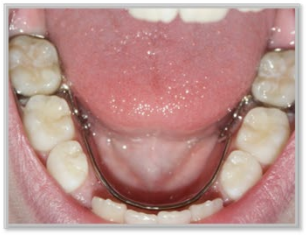
- Submission of dental record documentation is not required for payment
- A benefit only in conjunction with at least one of the following procedures: Comprehensive oral evaluation (D0150), Periodic oral evaluation (D0120); Prophylaxis (D1110 or D1120); Scaling and root planning (D4341 or D4342); or periodontal maintenance (D4910)
- A benefit to encourage tobacco cessation; not to be billed for those who are not tobacco/vape users

D1320

- Documentation in the provider record of a face-to-face encounter shall include:
  - The five A's of tobacco dependence – Ask, Advise, Assess, Assist, Arrange. If unwilling to quit document the patient's expressed roadblocks
- Provider bulletin – May 2019 (Vol 35, Number 15)
  - https://dental.dhcs.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_15.pdf

Space Maintainers





Space Maintainers

- Prior authorization not required
- Require pre-operative radiograph(s)
- Unilateral space maintainers require a quadrant code
  - Our system will assign an arch code for bilateral space maintainers based on the procedure code
- Indicate the missing primary molar(s)
- Not a benefit for anterior teeth

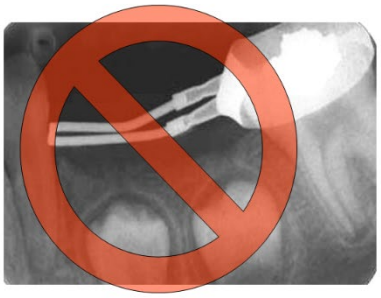
Unilateral Space Maintainers

- Fixed, D1510
- Distal Shoe Space Maintainer – Fixed, D1575
- Quadrant code required
- Indicate missing primary molar
- Pre-op radiograph required

Unilateral removable space maintainer D1520 is not a benefit

Unilateral Space Maintainers

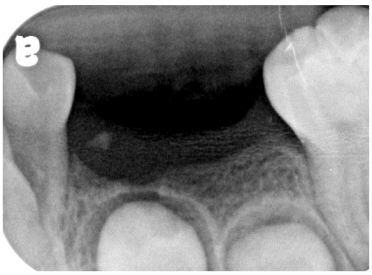
- A fixed unilateral space maintainer is only a benefit to maintain the space of a single primary molar
- ARC 197A
- Bilateral space maintainer indicated



A unilateral space maintainer for more than one molar space is not a benefit of the Program.

Bilateral Space Maintainers

- Fixed, D1516 Maxilla
- Fixed, D1517 Mandible
- Removable, D1526 Maxilla
- Removable, D1527 Mandible
- Arch code required
- Indicate missing primary molars

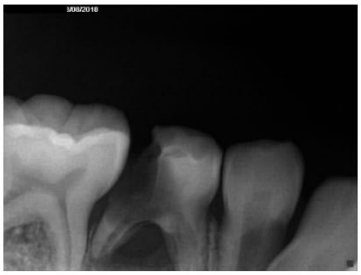


Bilateral Space Maintainers

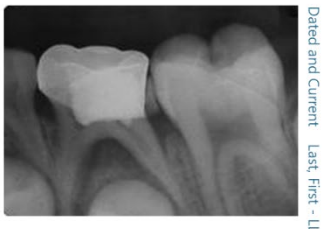
- Pre-op radiograph or radiographs required
  - More than one radiograph if molars missing on opposite sides
- Bilateral space maintainers shall be attached to teeth on both sides of the arch
- All clasps, rests, and adjustments included in fee

Space Maintainer Radiographs

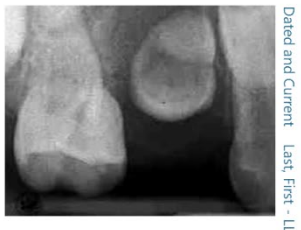
- Should depict adequate space and that the premolar is not near eruption



Space Maintainer Radiographs



- Before the extraction

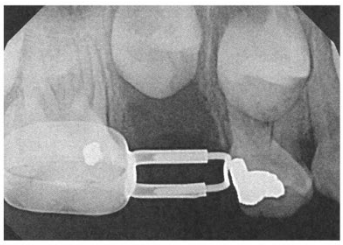


- After extraction but before placement of space maintainer is also acceptable

Space Maintainer Radiographs

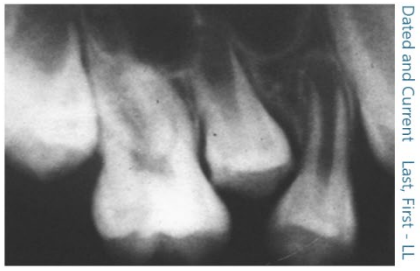
029E

» Payment denied due to date of radiograph/photograph is after the date of service or appears to be post-operative



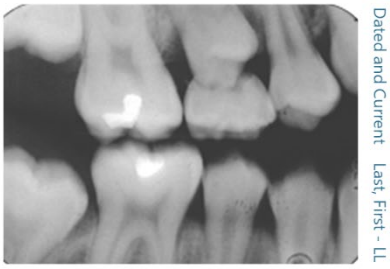
Adjudication Reason Code 191

» Insufficient space for eruption



Adjudication Reason Code 192

» Permanent tooth near eruption



Space Maintainer Replacement

- Space maintainers are a benefit once per lifetime
- Replacement requires documentation and current radiograph

Space Maintainer Recementation

- D1551, D1552, D1553
- Requires quadrant or arch code as appropriate
- A benefit once per billing provider without documentation
- Additional recementation procedures require documentation
- A benefit under age 18

Space Maintainer Removal

- D1556, D1557, D1558
- Requires quadrant or arch code as appropriate
- No documentation or radiographs required
- Not a benefit to original billing provider – removal included in fee for placement

Restorative Procedures

Restorative Procedures

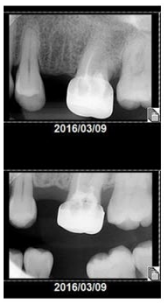
- For amalgams, composites and prefabricated crowns:
  - Prior authorization not required – submit on a claim
  - Submission of pre-operative radiographs not required for payment, with the following exceptions:

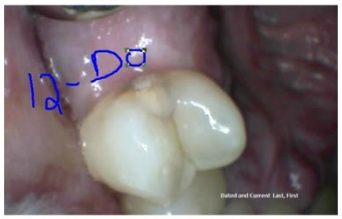
Restorative Radiographs Required

- Anterior proximal restoration (amalgam/composite) when submitted as a two- or three-surface restoration
- Replacement restoration by the same provider
  - Primary teeth within the first 12 months
  - Permanent teeth within the first 36 months
  - Payable when replacement is beyond the control of the provider
    - Loss of restoration, fracture, recurrent caries
  - A replacement restoration is: same tooth, same surfaces

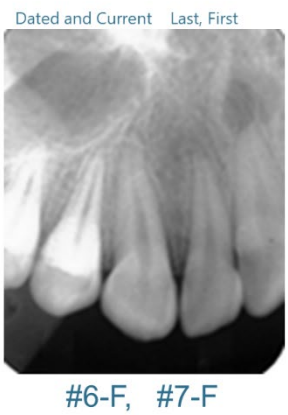
Use of Photos

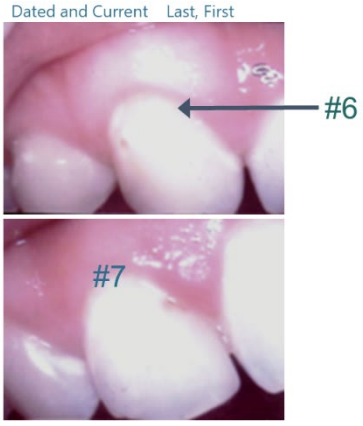
- When radiographs fail to demonstrate need, submit photographs as additional documentation





#12 DO





Restorative Procedures

- When radiographs are required, unacceptable documentation for lack of radiographs includes
  - Patient/parent refused radiographs
  - Cannot take radiographs because provider does not have access to portable x-ray unit
  - Unmanageable or uncooperative

Senate Bill 1403

- Effective January 1, 2007
- Applies to members under four years of age, or
- Regardless of age, has a developmental disability, as defined in W&I Code section 4512.
  - Provider must establish and document that the member is a registered consumer of the Department of Developmental Services

Senate Bill 1403

- One current diagnostic radiograph or photograph showing caries on at least one tooth surface will be sufficient for payment of all restorations and prefabricated crowns
- The requirement for arch films will be waived for prefabricated crowns on permanent teeth

Amalgams and Composites

- Surfaces listed on the same CSL are considered connected
- Non-connected restorations on the same tooth for the same date of service shall be submitted on separate CSLs
- Example: Tooth #8
  - MI D2331 + DI D2331 performed on same Date of Service
  - Will be paid as MID – D2332

Amalgams and Composites

- Separate restorations on the same tooth are allowable when different materials are used
- Example: Tooth #3
  - MOD Amalgam D2160
  - B Composite D2391
  - Both restorations payable

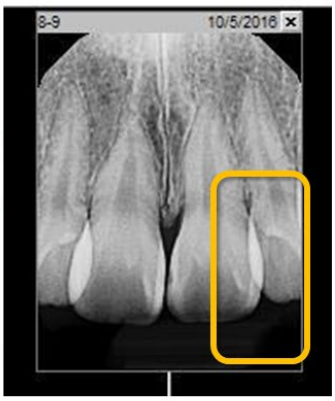
Amalgams and Composites

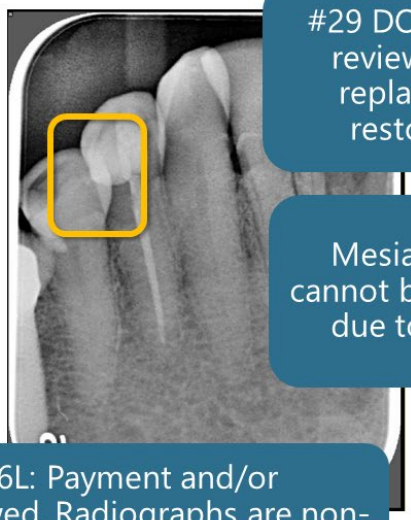
- Two separate single surfaces payable on a tooth when surfaces are non-adjacent
- Example: #8
  - D2330 M Composite
  - D2330 D Composite
  - Both are payable

ARC 266L

#9 ML required review due to replacement restoration

Distal contact cannot be evaluated due to overlap





#29 DO required review due to replacement restoration

Mesial contact cannot be evaluated due to overlap

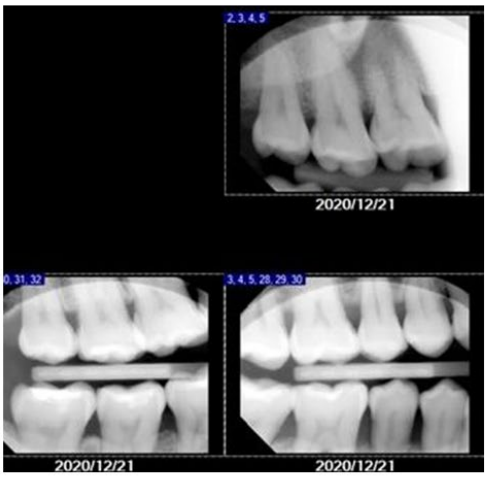
Both denied 266L: Payment and/or authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting

ARC 121

#2 O would not usually require review. Let's assume is a *replacement restoration* so requires radiograph and review

Recurrent caries to DEJ or loss of restoration or tooth structure not seen on radiograph

O #2 denied with ARC 121: Radiographs do not substantiate immediate need for restoration of surface(s) requested



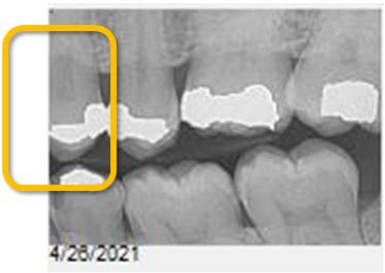
ARC 123

#12 DO is a *replacement restoration*

Fracture of amalgam is evident but mesial contact is not depicted

DO #12 denied with ARC 123: Radiograph or photograph does not depict the entire tooth to verify the requested surfaces or procedure

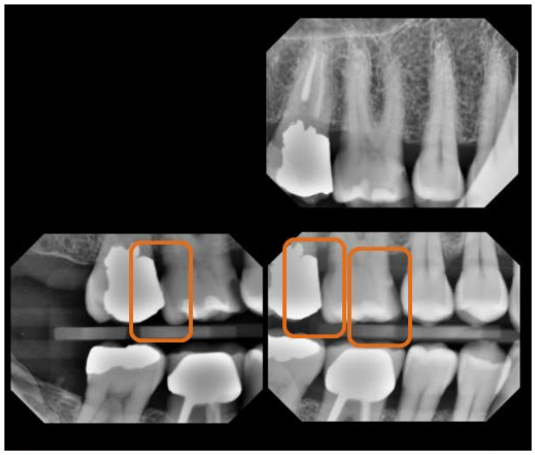
No mesial contact!



ARC 124

#3 MO was restored two years ago

#3 MO on new claim – when the same provider bills again within 36 months, it is a *replacement restoration* so it requires radiograph and review



#3 MO restoration appears to have been lost

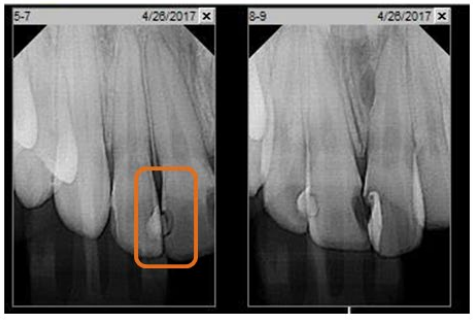
However, there also appears to be untreated root caries at the distal

Denied with ARC 124: Radiograph or photograph indicate additional surface(s) require treatment

ARC 124

#8 ML requested as D2331

This combination requires a radiograph and review



Mesial lesion is evident but distal restoration appears to have failed

Denied with ARC 124: Radiograph or photograph indicate additional surface(s) require treatment

Restorative Procedures

- If bitewings are submitted and the destruction appears to encroach upon the pulp, submit a PA radiograph fully depicting the apex/apices
- When restorative procedures are reviewed, PA radiographs are required for endodontically treated permanent teeth

Crowns

Laboratory-Processed Crowns

- Requires prior authorization
- Tooth #
- PA Radiograph of entire tooth
- Post-Endo film (if applicable)
- Radiographs to demonstrate arch integrity if age 21 or older
  - Waived if RCT completed within past six months

Laboratory-Processed Crown Codes

- Resin (Indirect) – D2710, D2712, D2721
- Porcelain – D2740
- Porcelain fused/predominantly base metal – D2751
- ¾ Crowns D2781, D2783
- Cast base metal – D2791

Lab Crown Policies

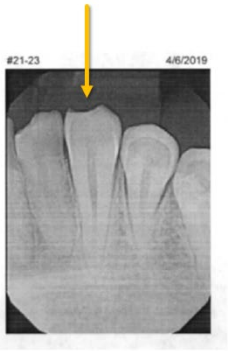
- A benefit once in a 5-year period
- Not a benefit for
  - Members under age 13
  - 3rd molars unless the tooth first meets the criteria and is occupying the 1st or 2nd molar position
- Noble metals are not a benefit
- Payment is made upon final cementation; there is no partial payment provision for crowns
- A benefit for endodontically treated premolars and molars, and can be authorized on the same TAR as root canal

Lab Crowns - Anterior

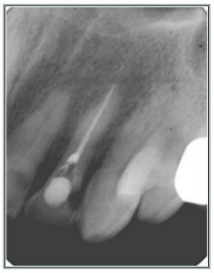
- Involvement of four or more surfaces including an incisal angle, or
- Destruction of more than 50% of the anatomical crown
- History of endodontic therapy not an automatic qualifier for crown in the anterior region

Lab Crowns - Anterior

- #22 Denied with ARC 113



- #10 Allowed even without incisal edge involvement due to greater than 50% destruction of anatomical crown

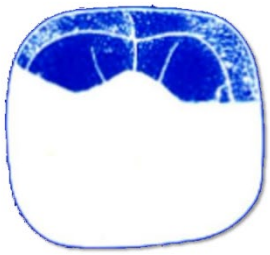


Lab Crowns - Premolar

- 3 surfaces including 1 cusp involved when there is no history of endodontic therapy

Lab Crowns - Molar

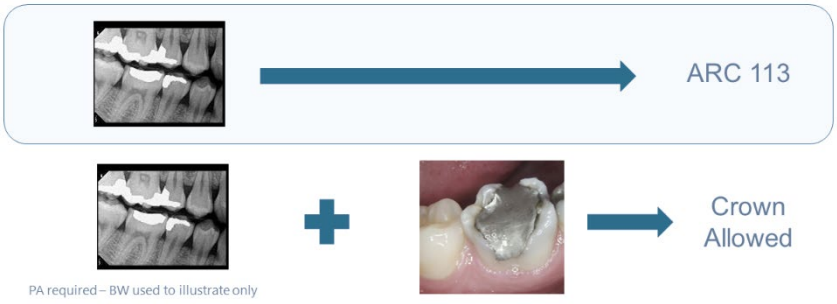
- 4 surfaces including 2 cusps involved when there is no history of endodontic therapy



ARC 113, 113A

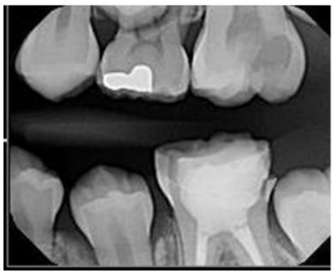
- ARC 113 – tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment
- ARC 113A – Per history, radiographs, or photographs it has been determined that this tooth has been recently restored with a restoration or prefabricated crown

Photos and Crowns



ARC 113B

- Per radiographs, the tooth/eruption pattern is developmentally immature.
- Please re-evaluate for alternate treatment



ARC 268

- When a crown does not demonstrate open margin or recurrent decay on a radiograph, it can be denied with ARC 268
- Consider submitting narrative documentation
- A photo can be used to supplement the radiographs in this case

D2952 – D2954

- Cast or prefabricated post & core do not require prior authorization
- Requires tooth number, PA radiograph, and arch integrity radiographs (age 21 and older)
- Tooth must be endodontically treated
- A benefit only in conjunction with allowable prefabricated or lab crowns – the crown must have been paid or authorized by the Program

Prefabricated Crowns

Prefabricated Crowns

- Stainless Steel (Primary tooth) – D2930
- Stainless Steel (Permanent tooth) – D2931
- Resin (Primary or Permanent tooth) – D2932
- Stainless Steel with Resin Window (Primary or Permanent tooth) – D2933

Prefabricated Crowns – Primary Teeth

- Prior authorization is not required
- Tooth # required
- A benefit once in a 12-month period

Prefabricated Crowns – Primary Teeth

- To qualify for a prefabricated crown, a primary tooth must demonstrate:
  - Three or more tooth surfaces involved or
  - Extensive two-surface interproximal restoration or
  - In conjunction with pulpotomy

Prefabricated Crowns – Permanent Teeth

- D2931, D2932, D2933
- Prior authorization not required
- Tooth # required
- A benefit once in a 36-month period

Endodontics

D3220

Therapeutic pulpotomy, primary tooth

» No prior authorization, documentation, or radiograph required

» A benefit once per tooth

D3230 D3240

Pulpectomy, primary tooth

» No prior authorization, documentation, or radiograph required

» A benefit once per tooth

D3310 D3320 D3330

Initial root canal therapy

» Prior authorization not required for children
- Can be submitted on claim – no radiographs required for payment

» Prior authorization is required for adults

» Requires a periapical depicting entire tooth
- Also requires arch integrity radiographs for adults

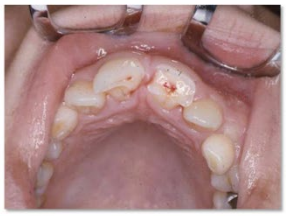
» Tooth will be evaluated for longevity, periodontal status, and restorability

D3310 D3320 D3330

- Not a benefit for 3rd molars unless occupying the 1st or 2nd molar position
- Date of service on NOA is final treatment date
- Post-treatment radiograph not required for payment
  - Documentation and appropriate radiographs must still be maintained in the treatment record in accordance with Standards of Care
- Fee includes
  - All treatment and post-treatment radiographs
  - Temporary restoration

D3310 D3320 D3330

- Prior authorization may be waived when one of the following has occurred
  - Tooth has been accidentally avulsed
  - Crown fracture has exposed vital pulp tissue



D3346 D3347 D3348

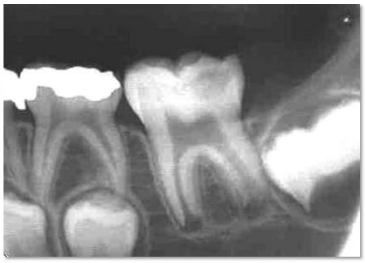
Root canal re-treatment

- Same prior authorization guidelines as initial root canal therapy
- Requires written documentation including rationale for treatment (if not evident on radiograph)
- Not a benefit to original provider within 12 months of initial treatment

D3222

Partial Pulpotomy for Apexogenesis

- For vital permanent teeth with incomplete root development
- A benefit once per tooth
- Under age 21
- Requires
  - Prior authorization
  - PA radiograph



D3351

Apexification

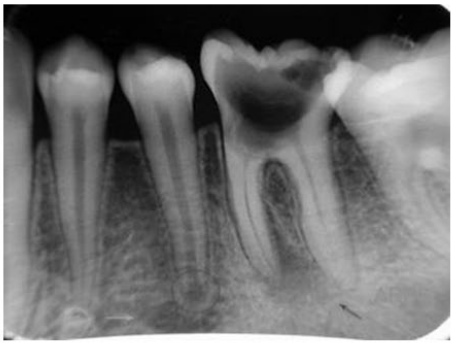
- A benefit for permanent teeth under age 21
- Initial visit – D3351
- Requires
  - Prior authorization
  - PA radiograph
- After D3351 completed member is eligible for D3352 once on a claim

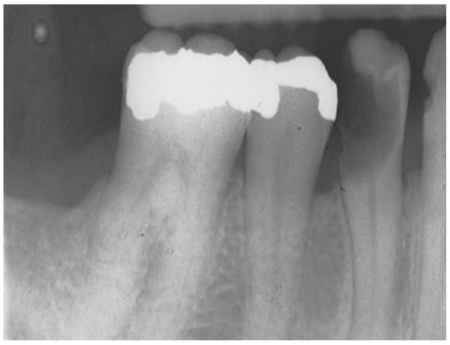
D3921 – Decoronation or Submergence of an Erupted Tooth

- Prior authorization is required
- Tooth code is required
- Periapical radiograph is required
- Narrative documentation is required – describe the specific conditions addressed by the procedure and rationale demonstrating medical necessity

ARC 271F

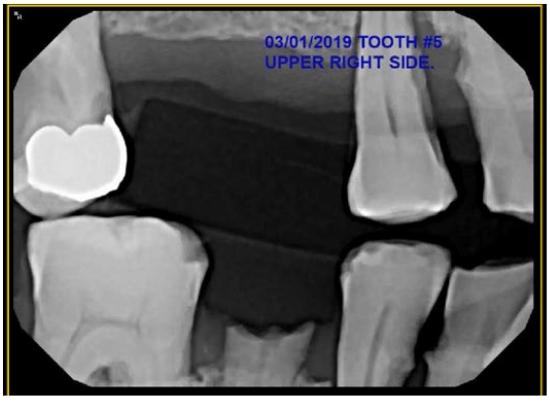
» Gross destruction of crown or root

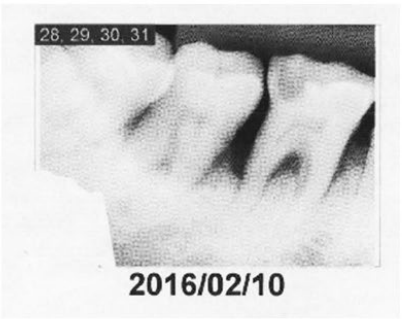




ARC 271A

» Bone loss, mobility, periodontal pathology





Periodontics

D4341 - D4342

Scaling and Root Planing

- A benefit once per quadrant every 24 months
- Requires:
  - Prior authorization
  - Periapical radiographs of all involved teeth in the requested quadrant and bitewings
  - Quadrant code
- Periodontal chart/definitive periodontal diagnosis not required

D4341 - D4342

- Procedure D4341 a benefit when at least four teeth in the quadrant qualify for treatment
- Procedure D4342 a benefit when one, two, or three teeth in the quadrant qualify for treatment

D4341 - D4342

- For pregnant/postpartum members, scaling and root planing can be submitted on a TAR or a claim
- Indicate “pregnant” or “postpartum”
- Requires
  - Periapical radiographs of involved teeth (bitewings can be waived)
  - Quadrant code

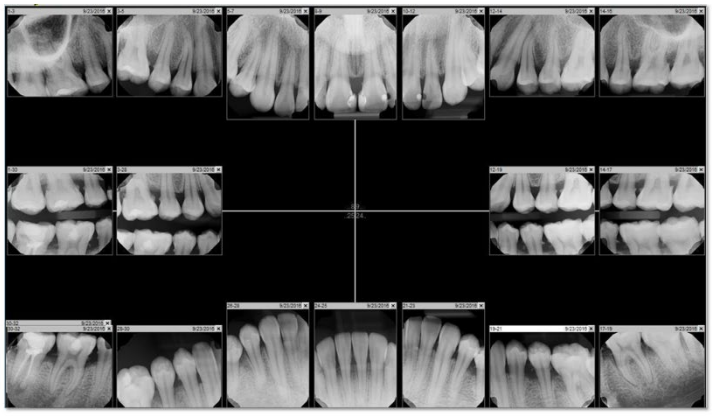
D4341 - D4342

- Only teeth that qualify as diseased are considered in the count for the number of teeth to be treated in a particular quadrant
- Teeth will not be counted as qualifying when they are indicated for extraction

D4341 - D4342

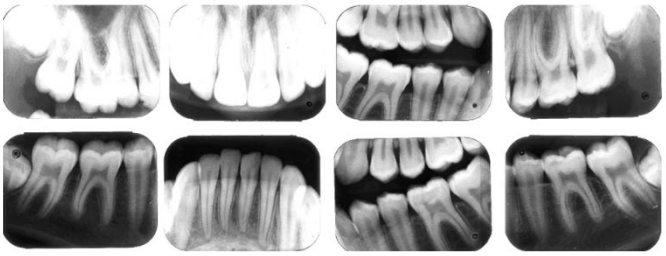
- Each qualifying tooth must show radiographic evidence of:
  - Significant amount of bone loss or presence of calculus deposits (on root surfaces)
  - Restorability
  - Arch integrity

D4341 - D4342

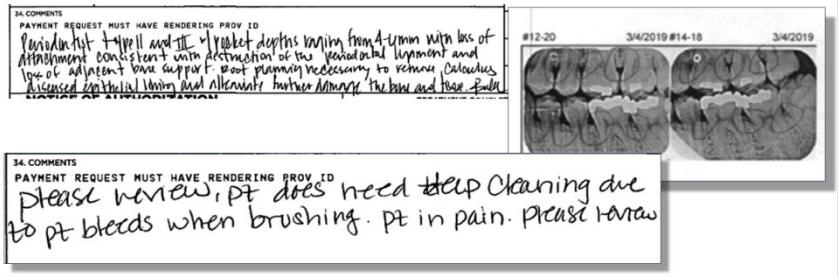


ARC 081

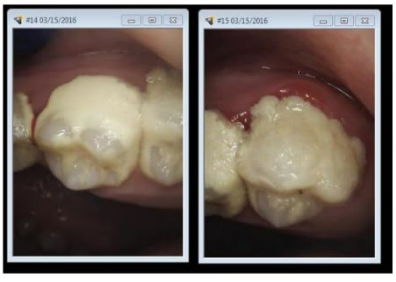
» Procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidence by the submitted radiographs

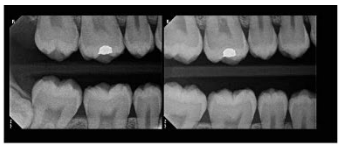


D4341 – D4342



D4341 – D4342





Even with large amounts of calculus on enamel, when accompanied by these radiographs showing no bone loss, this is by definition a prophylaxis case

D4346

- This procedure is considered included in the fee for another procedure and is not payable separately
- A procedure that is included in a global procedure cannot be billed to the member under any circumstances

D4341 - D4342

- Prophylaxis is not a benefit on the same date of service as scaling and root planing
- There is no restriction regarding the number of quadrants per date of service

D4910

Periodontal Maintenance

- A benefit for all members
- A full-mouth treatment
- Does not require prior authorization, periodontal charting, or radiographs

D4910

- If Scaling and Root Planing was completed outside of the Medi-Cal Dental Program, submit a ledger and/or chart note with your claim as confirmation of date of service
  - If the member does not qualify for D4341/D4342 based on criteria, they do not qualify for D4910

D4910

- A benefit:
  - Only when preceded by periodontal scaling and root planing
  - Only after completing all necessary scaling and root planing
  - Only in the 24-month period following the last paid scaling and root planing
  - Once per calendar quarter
- Not a benefit in the same calendar quarter as scaling and root planing, nor in the same calendar quarter as prophylaxis by the same provider

D4910

» Example of one calendar quarter:

JANUARY						
S	M	T	W	R	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY						
S	M	T	W	R	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

MARCH						
S	M	T	W	R	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Perio Treatment Process

Authorize D4341 or D4342, then:

Render D4341/D4342

- No restriction on number of quadrants per date of service

Render Prophylaxis in same calendar quarter as D4341/D4342

- Prophylaxis and SC/RP can be rendered in the same calendar quarter, but it is not required
- No restriction on time before or after SC/RP

Begin rendering D4910 in the next calendar quarter

- No restriction on time after SC/RP but D4910 must not be in same calendar quarter as prophy or SC/RP
- Reauthorize D4341/D4342 after 24 months

Removable Prosthodontics

Removable Prosthodontics

Complete Dentures	Resin-Based RPDs	Cast RPDs
D5110 D5120	D5211 D5212	D5213 D5214

- Each of these procedure codes requires:
  - Prior authorization
  - Radiographs of all remaining teeth in both arches
  - A properly completed DC054 form

Removable Prosthodontics

- Immediate Dentures D5130, D5140 do **not** require:
  - Prior authorization
  - Radiographs
  - DC 054 form

Removable Prosthodontics

- Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when full treatment has been completed
- Any revision of a prior authorized treatment plan requires a new TAR

Removable Prosthodontics

- Precision attachments and other specialized techniques are included in the fee for the appliance
- The fee includes all adjustments for 6 months
- Relines are a benefit after 6 months if the case involved extractions, and 12 months if did not

Removable Prosthodontics

- A benefit only once in a five-year period
- Authorization for replacement can be considered when existing prosthesis cannot be made serviceable by repair, replacement of broken/missing teeth, or reline
- Use the date prosthesis sent to lab for acrylic processing as the date of service
- Prosthesis must be delivered and in use by member before submitting for payment

Removable Prosthodontics

- Undeliverable denture payable at 80%:
  - Indicate reason for non-delivery
  - Box 44 – date prosthesis ordered from lab
  - Submit NOA with lab invoice indicating prosthesis was processed in acrylic
  - Keep prosthesis in office in a deliverable condition for one year

D5211 - D5212

Resin base RPDs

- A benefit when replacing a permanent anterior tooth/teeth, or
- The arch lacks posterior balanced occlusion
- D5211 - D5212 do not need to oppose a complete denture to be a benefit of the Program

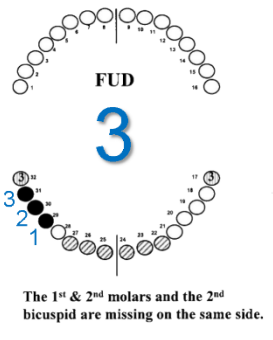
D5213 - D5214

Cast metal framework RPDs

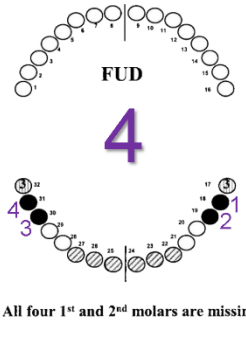
- A benefit only when opposing a full denture and when the arch lacks posterior balanced occlusion

Lack of Posterior Balanced Occlusion

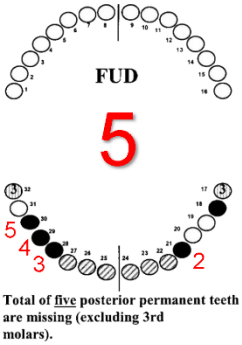
aka "The 3, 4, 5 Rule"



The 1st & 2nd molars and the 2nd bicuspid are missing on the same side.



All four 1st and 2nd molars are missing.



Total of five posterior permanent teeth are missing (excluding 3rd molars).

DC 054 Form

Justification of Need for Prosthesis

» Submit current version of form (09/18)

» Requires

- Member Name
- Date DC 054 was completed
- Provider signature

DC 054 Form

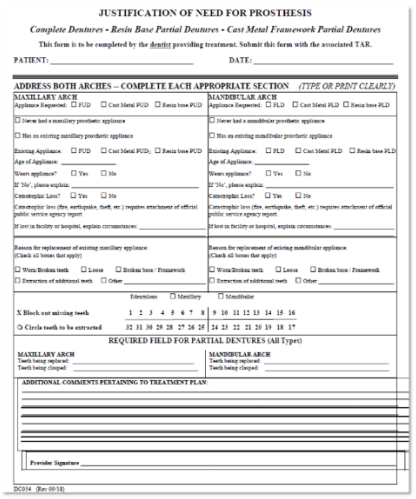
» Documentation must include:

- Both arches
- Missing teeth
- Teeth to be extracted
- Teeth being replaced by the requested partial prosthesis (excluding third molars)
- Teeth being clasped for partial dentures

DC054 Form

» You must submit a prosthetics form to communicate your treatment plan to Medi-Cal Dental

» This is the DC054 form



JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ DATE: _____

ADDRESS BOTH ARCHES – COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

MAXILLARY ARCH
Appliance Requested: ☐ FUD ☐ Cast Metal FUD ☐ Resin base FUD

☐ Never had a maxillary prosthetic appliance

☐ Has an existing maxillary prosthetic appliance

Existing Appliance: ☐ FUD ☐ Cast Metal FUD; ☐ Resin base FUD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing maxillary appliance:
(Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework

☐ Extraction of additional teeth ☐ Other _____

MANDIBULAR ARCH
Appliance Requested: ☐ FLD ☐ Cast Metal FLD ☐ Resin base FLD

☐ Never had a mandibular prosthetic appliance

☐ Has an existing mandibular prosthetic appliance

Existing Appliance: ☐ FLD ☐ Cast Metal FLD ☐ Resin base FLD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing mandibular appliance:
(Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework

☐ Extraction of additional teeth ☐ Other _____

Edentulous ☐ Maxillary ☐ Mandibular

X Block out missing teeth: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16

○ Circle teeth to be extracted: 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth being replaced: _____
Teeth being clasped: _____

MANDIBULAR ARCH
Teeth being replaced: _____
Teeth being clasped: _____

ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:

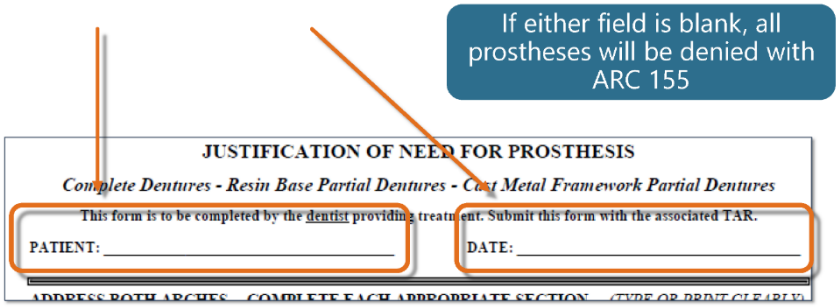
Provider Signature _____

DC054 (Rev 09/18)

DC054 Form

» Patient name and date form filled are required

If either field is blank, all prostheses will be denied with ARC 155


JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

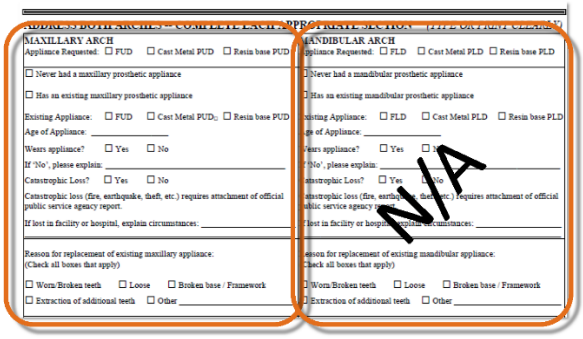
This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ DATE: _____

DC054 Form

» There is a section for the maxillary arch

» And a section for the mandibular arch

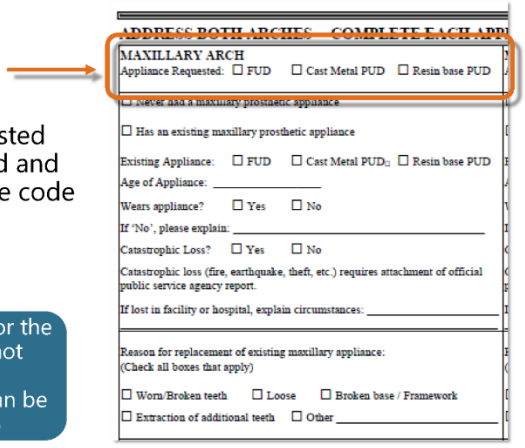


Both arches must be addressed, even if an appliance is not requested for both arches

For example, if no mandibular appliance is requested, you could write "N/A" over this area

DC054 Form

» The appliance type requested must have its box checked and must match the procedure code on the TAR


MAXILLARY ARCH
Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD

☐ Has an existing maxillary prosthetic appliance

Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing maxillary appliance:
(Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework

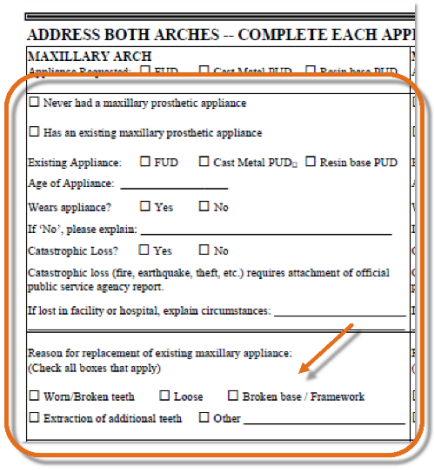
☐ Extraction of additional teeth ☐ Other _____

If the box is not checked or the procedure code does not match the Appliance Requested, procedures can be denied with ARC 155

DC054 Form

- If there is an existing appliance, note the type and age of appliance document why it needs replacement

If you indicate the member wears an existing appliance and do not indicate need for replacement, the requested appliance could be denied with ARC 268.


ADDRESS BOTH ARCHES -- COMPLETE EACH APPL

MAXILLARY ARCH

☐ Never had a maxillary prosthetic appliance

☐ Has an existing maxillary prosthetic appliance

Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If 'No', please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances: _____

Reason for replacement of existing maxillary appliance: (Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework

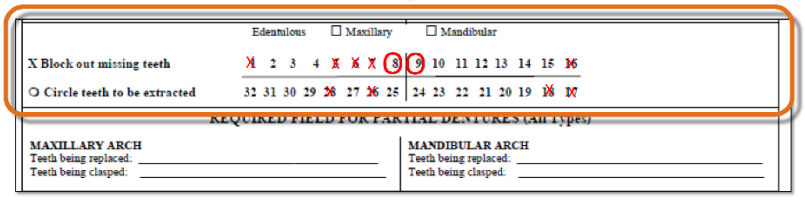
☐ Extraction of additional teeth ☐ Other _____

DC054 Form

- You must indicate teeth already missing by crossing them out with an "X" and indicate teeth that are going to be extracted by circling them

You can check the box to mark an arch as currently edentulous rather than crossing out all teeth

Both arches must be accurately addressed, even when an appliance is not requested for the arch


☐ Edentulous ☐ Maxillary ☐ Mandibular

X Block out missing teeth — X 2 3 4 X X X 8 9 10 11 12 13 14 15 X

○ Circle teeth to be extracted — 32 31 30 29 X 27 X 25 | 24 23 22 21 20 19 X X

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth being replaced: _____
Teeth being clasped: _____

MANDIBULAR ARCH
Teeth being replaced: _____
Teeth being clasped: _____

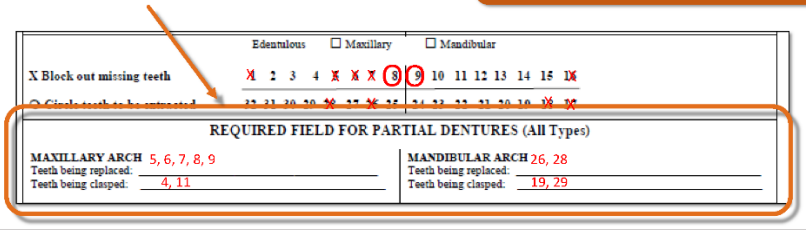
DC054 Form

- You must list teeth being replaced and teeth being clasped. A tooth being clasped is an abutment and thus requires complete depiction on a radiograph

When an abutment is not 100% depicted the appliance(s) can be denied with ARC 123

We will deny the appliance(s) when abutment(s) is/are not depicted at all

Appliances will be denied with ARC 149A or 314C when missing teeth do not or will not qualify for requested appliance


☐ Edentulous ☐ Maxillary ☐ Mandibular

X Block out missing teeth — X 2 3 4 X X X 8 9 10 11 12 13 14 15 X

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth being replaced: 5, 6, 7, 8, 9
Teeth being clasped: 4, 11

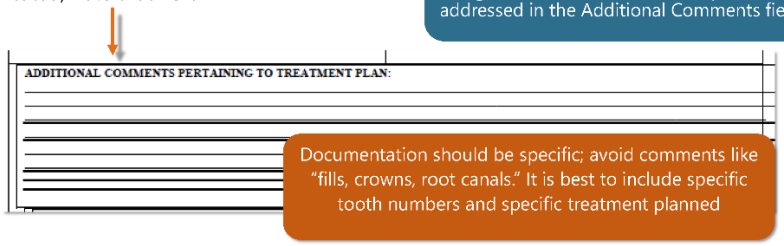
MANDIBULAR ARCH
Teeth being replaced: 26, 28
Teeth being clasped: 19, 29

DC054 Form

- The Additional Comments field is your opportunity to explain your plan in more detail
- If your patient requires RCT, crowns, or restorations before a partial denture is fabricated, note that here

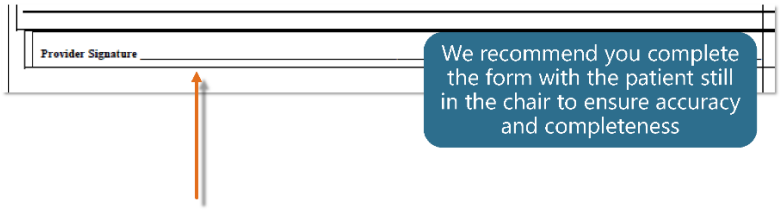
This is where you should address any pre-prosthetic treatment that is needed and that impacts the design of a partial denture

Special attention should be paid to the abutment teeth – root canals, crowns, and large restorations must be completed or addressed in the Additional Comments field



Documentation should be specific; avoid comments like "fills, crowns, root canals." It is best to include specific tooth numbers and specific treatment planned

DC054 Form



We recommend you complete the form with the patient still in the chair to ensure accuracy and completeness

- Finally, the document must be signed by the prescribing dentist and not by other staff.
- License number and/or NPI are **not** required

Denture and RPD Adjustments

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Not payable to same provider to 6 months after
  - Delivery of denture
  - Reline
  - Repair
  - Tissue Conditioning

Denture and RPD Repairs

- Payable once per date of service per billing provider
- Allowed twice per appliance in a 12-month period per billing provider
- Do not require
  - Prior authorization
  - Radiographs
  - Documentation

Relines

- A benefit once per 12 months
- D5211 D5212 do not qualify for indirect reline – only a chairside reline
- Do not require:
  - Prior authorization
  - Radiographs
  - Documentation

D5850 - D5851

Tissue Conditioning

- A benefit twice in a 36-month period (per prosthesis, not per provider) – Check Medi-Cal Dental Program history
- Allowable same date of service as insertion of immediate denture
- Does not require:
  - Prior authorization
  - Radiographs
  - Documentation

Extractions

Extractions

Procedure Code	Description
D7111	Coronal Remnant - deciduous tooth
D7140	Extraction of erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone or sectioning tooth
D7220	Impacted, soft tissue
D7230	Impacted, partial bony
D7240	Impacted, complete bony
D7241	Impacted, complete bony with surgical complications
D7250	Surgical removal of residual root (cutting procedure)

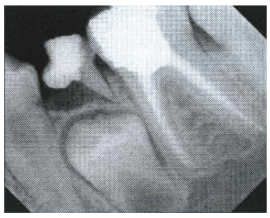
Extractions

- Fee includes:
  - Local anesthesia
  - Sutures
  - Routine post-operative care within 30 days
- Extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars are a benefit

D7111

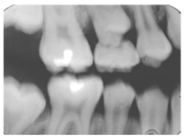
Extraction, coronal remnants, deciduous tooth

- Documentation/radiographs not required
- Requires tooth number
- Not a benefit for asymptomatic teeth



D7140

Extraction, erupted tooth or exposed root



- Radiographs not required
- Requires a tooth number
- Not a benefit
  - For asymptomatic teeth
  - For root removal by the same billing provider who performed the initial extraction
  - For primary teeth near exfoliation

Radiographs for Extractions

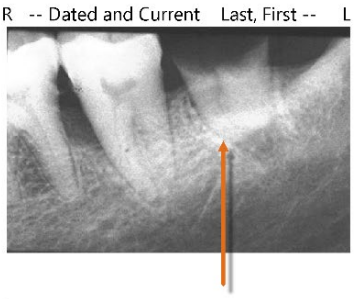
- No radiographs required for D7111 or D7140
- Radiographs required for
  - D7210
  - D7220
  - D7230
  - D7240
  - D7241
  - D7250
- Prior authorization not required for any extraction

No extraction requires prior authorization. This includes third molars.

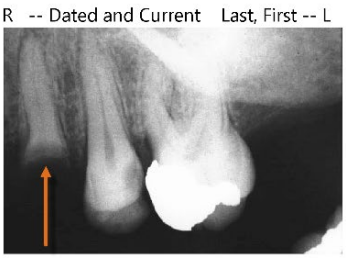
D7210

Surgical Removal

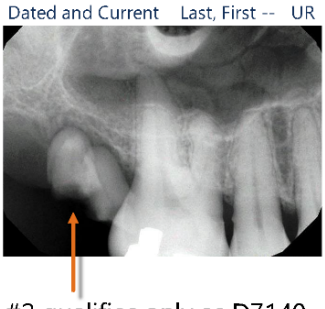
- A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth
- Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal



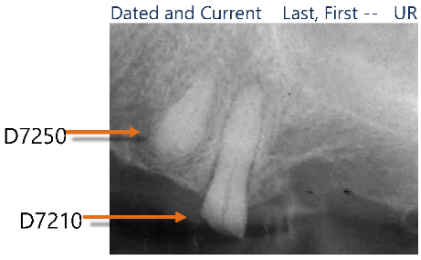
Surgical Removal D7210



- Cases like #17 and #12 qualify for D7210
- If billed as D7140 we would not upgrade
- These do not qualify as D7250

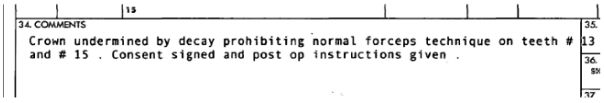


- #2 qualifies only as D7140



- The mesial tooth qualifies as D7250 due to being completely covered by bone on the radiograph
- The more distal tooth qualifies as D7210

Radiographs vs. Documentation



"Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal."

Third Molars

- Per Stedman's Medical Dictionary, 23rd Ed
- Unerupted tooth:
  - Denoting a tooth that has yet to pass through the alveolar process and perforate the gums
- Impacted tooth
  - Denoting a tooth so placed in the alveolus as to be incapable of eruption into normal position

Third Molars

- Document specific condition or medical necessity for each tooth identified for extraction
- Submit current radiograph depicting the entire tooth
- Prophylactic removal for some adverse condition that may or may not occur in the future is not a benefit

D7251

- Coronectomy – intentional partial tooth removal, impacted teeth only
  - Coronal portion of the impacted tooth (the crown) is removed and the residual tooth roots are intentionally left in the bone
  - Prior authorization is required
  - Require radiographs
    - Submit current diagnostic, preoperative periapical radiograph, or panoramic radiograph depicting the entire tooth
  - Requires documentation
    - Must describe the specific conditions addressed by the procedure and medical necessity
  - Requires tooth code

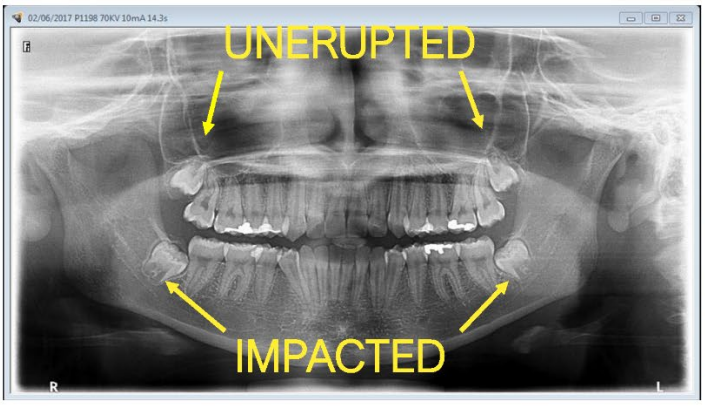
D6105

- Removal of implant body not by requiring bone removal or flap
  - Prior authorization is not required
  - Require radiographs for payment
    - Submit current diagnostic, preoperative periapical radiograph, or panoramic radiograph depicting the implant to be removed
  - Requires Documentation
    - Must describe the specific conditions addressed by the procedure and medical necessity and any pertinent history
  - Requires tooth code indicating the location of the implant

Note: the fee includes the removal of the implant crown

ARC 048

- Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence



D9930

Treatment of complications (post-surgical) – unusual circumstances

- A benefit within 30 days of extraction for
  - Dry socket
  - Excessive bleeding
  - Removal of bony fragment
  - Infection
  - Life-threatening allergy related to recent extraction
- Requires Documentation
  - Use formula for emergency visit

D7922

Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site

- This procedure is considered a "global code"
- Global codes are adjudicated with ARC 269A
  - (Included in the fee for another procedure and is not payable separately)
  - and thus cannot be billed to the member on a private-pay basis when associated with a procedure paid for by Medi-Cal Dental

Anesthesia

Anesthesia Procedures

- Deep Sedation/General Anesthesia
  - D9222 – first 15 minutes
  - D9223 – each additional15 minutes
- Analgesia, anxiolysis, inhalation of nitrous oxide (D9230)
- Intravenous conscious sedation/analgesia
  - D9239 – first 15 minutes
  - D9243 – each additional 15 minutes
- Non-intravenous conscious sedation (D9248)

Anesthesia Procedures

- General Policies:
- The administration of sedation and therapeutic drug injection D9610 is a benefit
  - In conjunction with payable associated procedures
  - Prior authorization or payment shall be denied if all associated procedures by the same provider are denied
- Only the most profound anesthesia paid

D9230

Nitrous oxide

- Does not require prior authorization
- No documentation required for members under age 16
- Age 16 or older
  - Documentation is required that indicates physical, behavioral, developmental or emotional condition that prohibits the member from adequately responding to provider's attempt to perform treatment

D9248

Non-intravenous conscious sedation

- Does not require prior authorization
- Requires written documentation
  - Under age 13 – agent and method of administration
  - Age 13 or older – agent, method of administration, and medical necessity

D9248

- Acceptable agents include, but are not limited to, Demerol, chloral hydrate, fentanyl, ketamine, Nembutal, valium, versed, Vistaril, etc.
- Acceptable methods of administration
  - Oral
  - Patch
  - Intramuscular
  - Subcutaneous
- A benefit once per date of service per provider

Anesthesia Procedures

- Provider who render D9222 or D9239 shall have valid anesthesia permits with the California Dental Board, and must have their permit on file with the Medi-Cal Dental Program
- Providers rendering D9222 or D9239 on Medi-Cal Dental Program members must be enrolled in the Program

Anesthesia Procedures

- D9222 and D9239 require prior authorization
- Authorization is granted for anesthesia, *not a particular length of time for anesthesia* – additional units of D9223 or D9243 can be added to your Notice of Authorization without additional evaluation on our part
  - When returned, the NOA is always evaluated for the correct quantity and adjusted down if necessary

Anesthesia Procedures

- With NOA, a signed anesthesia record is required that indicates
  - Anesthetic agent – induction agent must be documented
  - Length of anesthesia (start and stop time), not including prep or recovery time
    - Stop time = when anesthetist is no longer in the room with the patient

D9920

Behavior Management, By Report

- Cannot be prior authorized
- Requires documentation
  - Member must be a special needs individual – include medical diagnosis
  - Document reason for the need of additional time for a dental visit
- A benefit for four visits in a 12-month period
- Only in conjunction with procedures that are payable

D9920 ARCs

- 071A – Not payable when sedation is used as a behavior modification modality
- 071B – only payable when the member is a special needs member that requires additional time for a dental visit
- 071C – Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit
- https://dental.dhcs.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_14.pdf

Case Management

Case Management

- Designed for members with special health care needs who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers
- Examples of special health care needs include:
  - Physical
  - Developmental
  - Mental
  - Sensory
  - Behavioral
  - Cognitive or emotional impairment
  - Or some limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs

Case Management

- Referrals for Case Management Services are initiated by:
  - The member's Medi-Cal Dental provider and based on a current, comprehensive evaluation and treatment plan
  - Medical provider or other healthcare professional
  - Social Worker
- Case Management referral form is located on the Medi-Cal Dental website
  - Referrals are to be emailed
  - Referral forms are not accepted by mail

Early and Periodic Screening, Diagnostic, and Treatment (EPDST) Services

EPSDT

- Early and Periodic Screening, Diagnostic, and Treatment Services
- In accordance with the Social Security Act and federal regulations, DHCS must provide full-scope Medi-Cal members under age 21 with a comprehensive, high-quality array of preventive, diagnostic, and treatment services under EPSDT

EPSDT

- EPSDT services might or might not be part of the Manual of Criteria
- A service is medically necessary if it corrects or ameliorates defects and physical and mental illnesses or conditions
- A TAR is required when a procedure is not listed in the Manual of Criteria, or a service does not meet the published criteria for a procedure
  - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition

EPSDT Example

- Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive.
- With adequate documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT service.

EPSDT Example

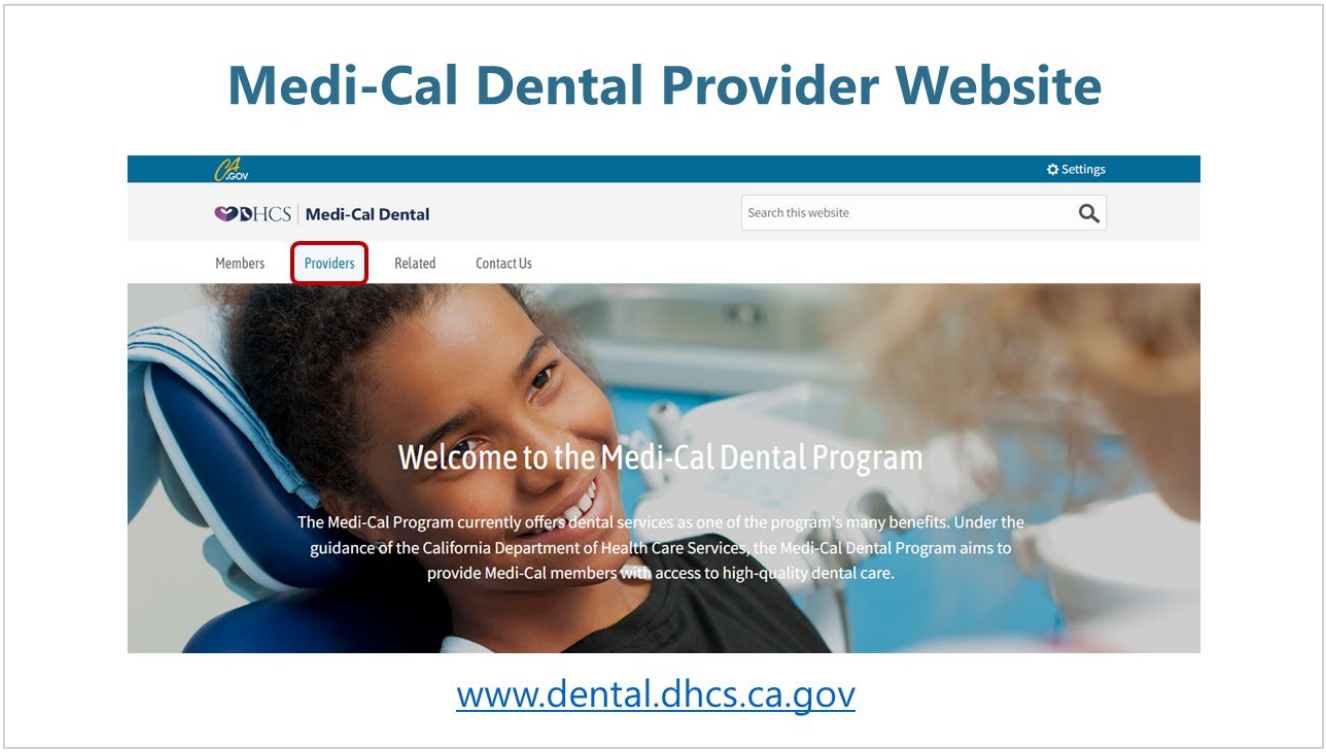
- Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planing.
- The Manual of Criteria states this procedure is not a benefit for patients under 13 years of age.
- However, as a documented medically necessary periodontal procedure, it may be authorized as an EPSDT service when there is radiographic evidence of bone loss.

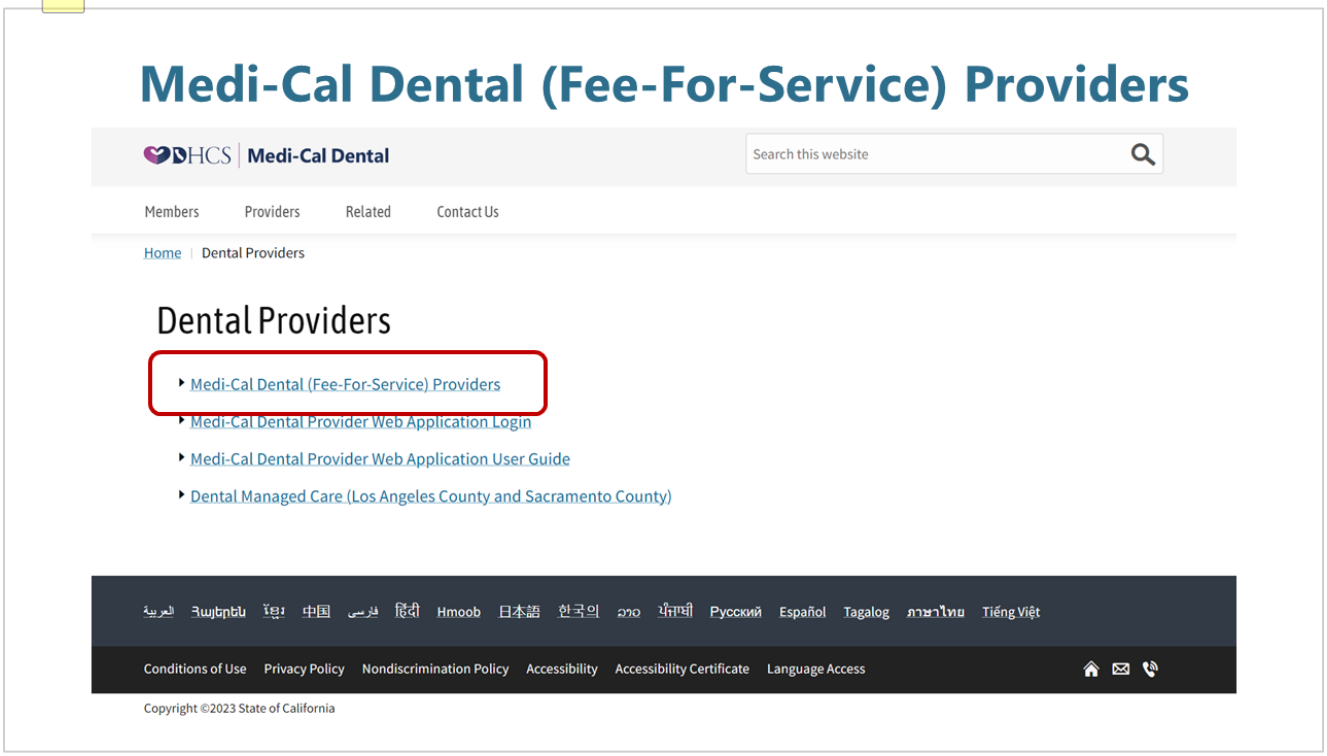
The Medi-Cal Dental Provider Website

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 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 Provider 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.

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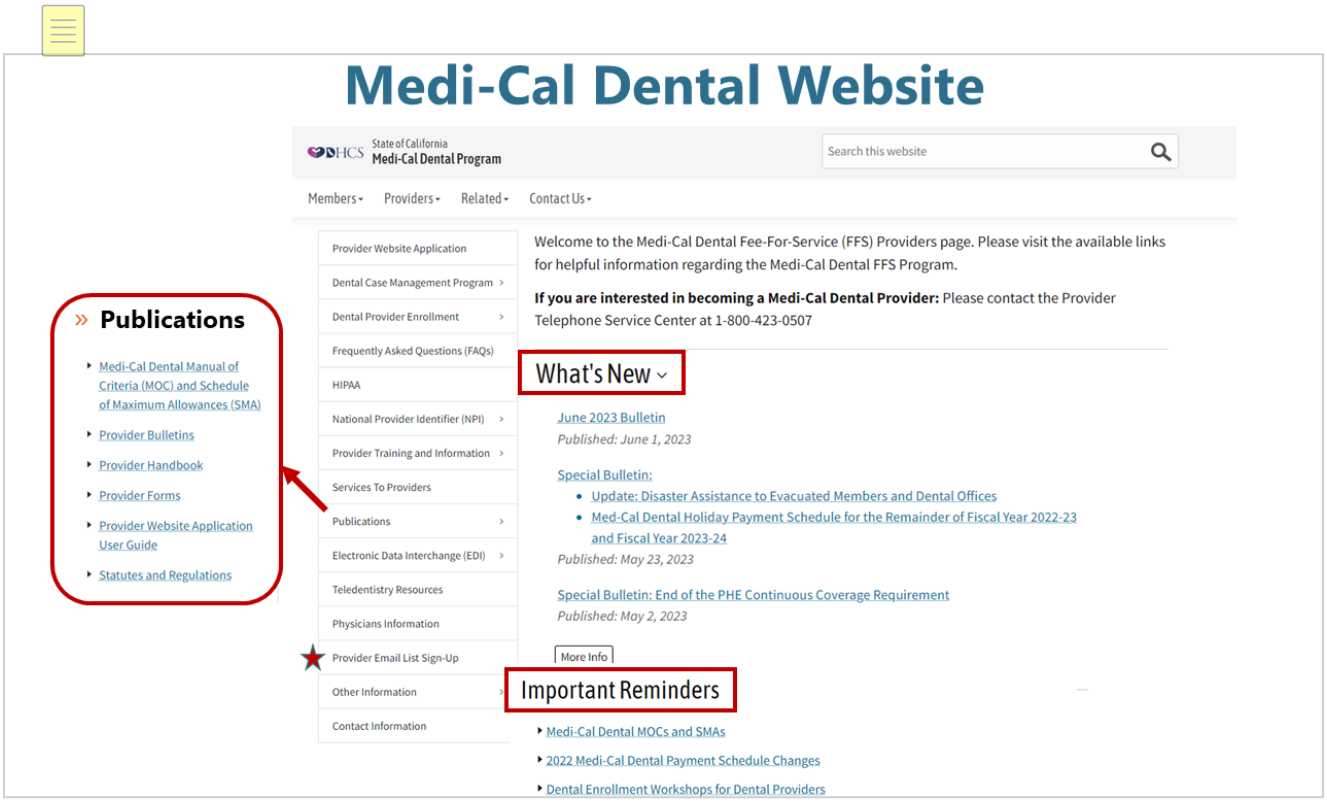
Medi-Cal Dental Website
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Dental Provider Enrollment
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Publications
Electronic Data Interchange (EDI)
Teledentistry Resources
Physicians Information
Provider Email List Sign-Up
Other Information
Contact Information
Publications
Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA)
Provider Bulletins
Provider Handbook
Provider Forms
Provider Website Application User Guide
Statutes and Regulations
Welcome to the Medi-Cal Dental Fee-For-Service (FFS) Providers page. Please visit the available links for helpful information regarding the Medi-Cal Dental FFS Program.
If you are interested in becoming a Medi-Cal Dental Provider: Please contact the Provider Telephone Service Center at 1-800-423-0507
What's New
June 2023 Bulletin
Published: June 1, 2023
Special Bulletin:
Update: Disaster Assistance to Evacuated Members and Dental Offices
Med-Cal Dental Holiday Payment Schedule for the Remainder of Fiscal Year 2022-23 and Fiscal Year 2023-24
Published: May 23, 2023
Special Bulletin: End of the PHE Continuous Coverage Requirement
Published: May 2, 2023
More Info
Important Reminders
Medi-Cal Dental MOCs and SMAs
2022 Medi-Cal Dental Payment Schedule Changes
Dental Enrollment Workshops for Dental Providers

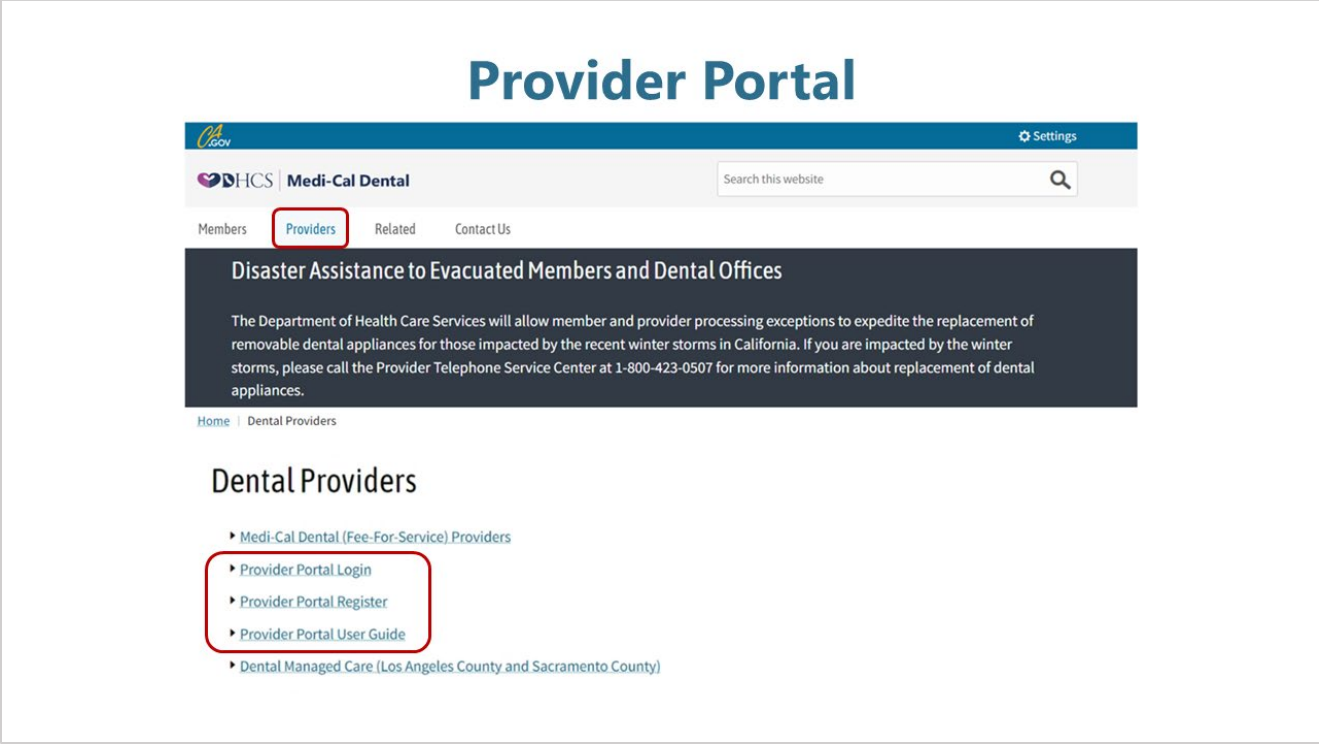
Medi-Cal Dental Provider Portal

Registered providers can check Medi-Cal Dental member's history online. This feature will display all dental services that a member received from Medi-Cal dental providers in the last five years, with individual provider information hidden. Each line item will include:

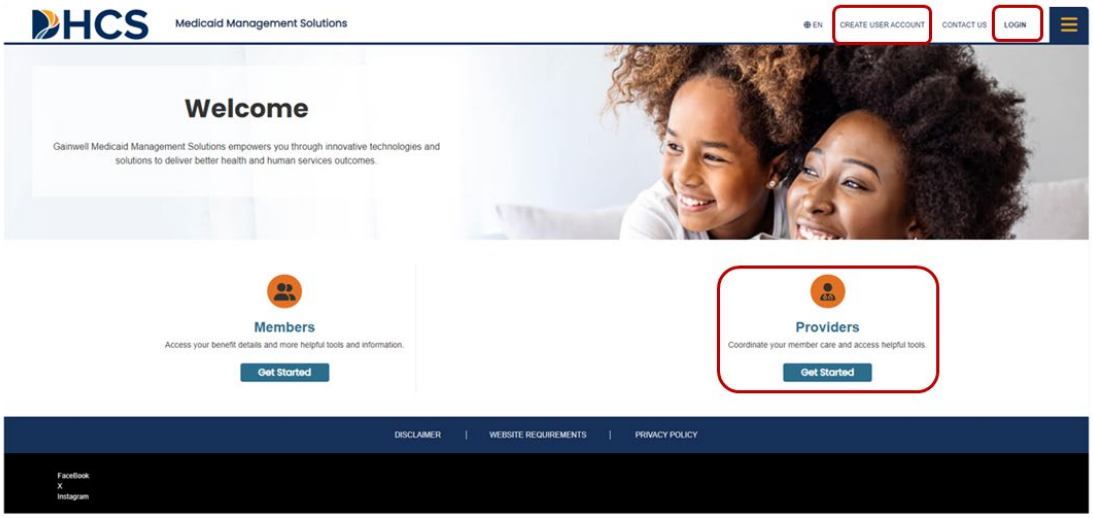
- Tooth information
- Procedure(s)
- Dates of service
- Denied/allowed status

Providers can also use the Provider Portal to access other important Medi-Cal Dental information, such as:

- Claim status and history
- Treatment Authorization Request status and history
- Weekly check amounts
- Monthly payment totals and year-to-date payment



Login Provider Portal



Enrollment

Enrollment: Become a Medi-Cal Provider

- To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the Medi-Cal Dental Program
- Enrollment is through the Provider Enrollment Division (PED) of DHCS
  - PED uses an online application portal called the Provider Application and Validation for Enrollment (PAVE)
  - Paper applications are not accepted!

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

Provider Application and Validation for Enrollment (PAVE) Portal

- Enrollment:
  - PAVE is for Providers who want to enroll in Medi-Cal Fee-for-Service
- Enrollment Changes:
  - All changes to your practice and/or license must be completed through PAVE
  - This must happen within 35 days of the change
- Enrollment Revalidation
  - DHCS will notify providers when revalidation is necessary

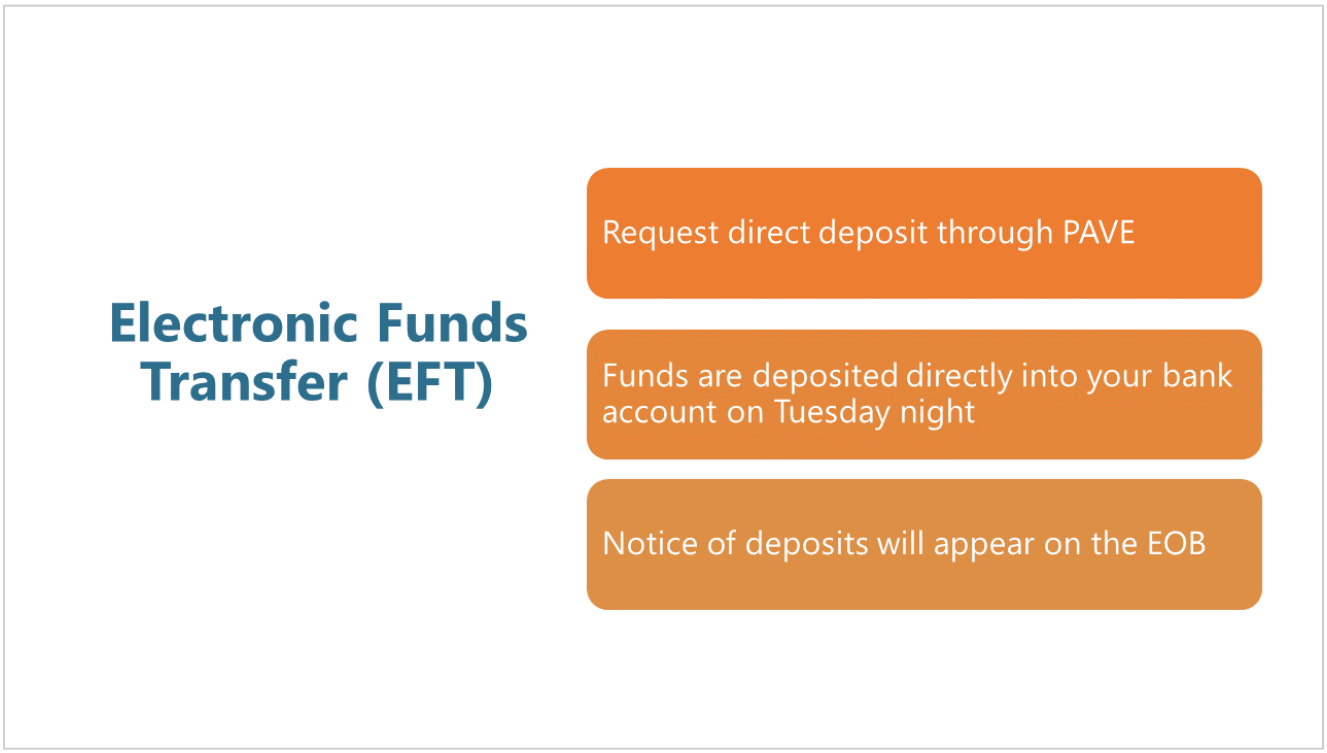
Enrollment: Welcome Packet

- Newly enrolled billing provider receives:
  - Billing Provider Number
  - Personal Identification Number (PIN)
  - Starter packet of forms
    - Re-order additional forms on the Medi-Cal Dental Website

Enrollment: Revalidation Process

- State regulations mandate that all providers are required to re-validate every 5 years to continue participating in the Medi-Cal Dental Program
- DHCS will send a revalidation notice to the provider when they are required to submit a revalidation application
- Dental providers submit revalidation applications using PAVE

See PED website or PED Message Center for more information.



Billing Providers

To receive payment for treating eligible Medi-Cal members, dental providers must be enrolled in the Medi-Cal Dental Program. On October 31, 2022, DHCS implemented the Provider Application and Validation for Enrollment (PAVE) Provider Portal to simplify and accelerate Medi-Cal enrollment processes for dental providers. The PAVE portal is a web-based application that allows dental providers to submit enrollment applications and required documentation to DHCS electronically.

PAVE website: Provider Enrollment Division (PED) (ca.gov)

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 Forms Re-order Request form found on the Medi-Cal Dental Website. Medi-Cal Dental Forms Reorder Request

Rendering Providers

Each provider who treats Medi-Cal members 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 billing service must complete the Medi-Cal Dental Provider and Billing Intermediary Application/Agreement found on the Medi-Cal Dental website. 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.

Enrollment Assistance

For Medi-Cal provider enrollment information, contact the Provider Enrollment Division (PED) using the Inquiry Form on PED's website under Provider Resources.

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

Providers can also contact the PED's Message Center:

- Phone Number (916) 323-1945
- Email PAVE@dhcs.ca.gov
- Send a message in PAVE

PAVE Technical Support (excluding State holidays)

For PAVE technical support, please call the PAVE Help Desk at (866) 252-1949.

- Help Desk is available Monday-Friday from 8:00 am – 6:00pm

PAVE Chat feature (excluding State holidays)

Providers can also use the PAVE Chat feature for support while in PAVE.

- Chat is available Monday-Friday from 8:00 am – 4:00 pm

Billing Inquiries and EFT Inquiries

Billing Inquiries

Please call the Customer Service Center (CSC) at (800) 423-0507.

- CSC Agents are available Monday-Friday from 8:00 am-5:00 pm
- Excluding State holidays

PIN Confirmation/Reset

A PIN cannot be confirmed or reset over the telephone. To confirm or reset a PIN, send a written request to:

Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

Eligibility

Eligibility

- Eligibility is established by the County Department of Social Services
  - Information is transferred to the Department of Health Care Services (DHCS)
- Benefits Identification Card is issued
- Eligibility is established on a monthly basis
  - Providers must verify a member's eligibility for each month the member is receiving services
- Eligibility Verification Confirmation Number (EVC)

Members Turning 21 Years of Age

- Benefit changes on the day they turn 21
- Authorization for services that were approved prior to the member's 21st birthday, may still be provided as long as:
  - The member continues to have Medi-Cal eligibility
  - The procedures were approved
  - Must be completed within the 180 days window as allowed on the Notice Of Authorization (NOA)

Medi-Cal Members Identification

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.

Verifying Member Identification

Members are required to sign their Benefits Identification Card (BIC) prior to presenting the card for services. Members who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. If a provider does not attempt to identify a member and provides services to an ineligible member, payment for those services may be disallowed. In certain instances, no identification verification is required, for example:

- When the member is 17 years of age or younger
- When the member is receiving emergency services
- When the member is a resident in a long-term care facility

If the member is unknown to the provider, the provider is required to make a "good-faith" effort to verify the member's identification by matching the name and signature on the Medi-Cal issued ID to that on a valid photo identification, such as:

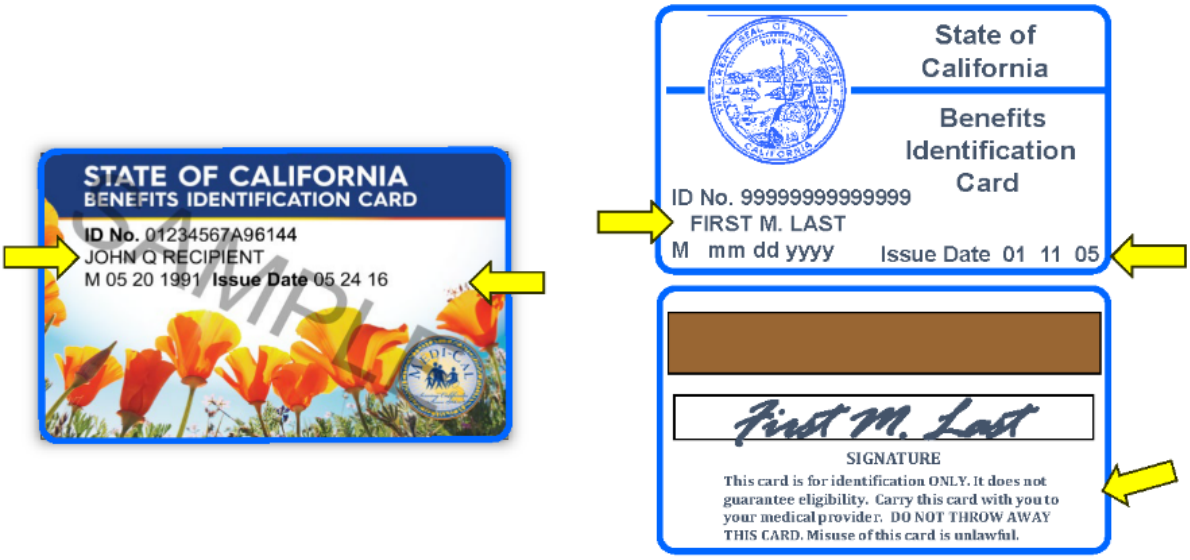
- A California driver's license
- An identification card issued by the Department of Motor Vehicles
- Any other document which appears to validate and establish identity

Medi-Cal dental providers must now accept expired photo identification (ID) up to six months from the date of expiration to verify a Medi-Cal patient's eligibility. During this grace period, providers may not deny Medi-Cal patients service for an expired ID.

Note: *The provider must retain a copy of this identification in the member's records.*

Any provider who suspects a member of abusing Medi-Cal Dental may call (800) 822-6222, Monday through Friday between 8:00 a.m. and 5:00 p.m.

Medi-Cal Benefits Identification Card (BIC)



Medi-Cal Benefits Identification Card (BIC)

- The Benefits Identification Card contains information to enable providers to access eligibility
  - NOT a verification of eligibility
  - NOT guarantee for payment
  - Make a copy of the BIC for the member record
- Verification of Identification
  - All paper cards (Immediate Need, CHDP, Presumptive Eligibility Cards) are used for ID purposes only.
  - Make a copy of the ID for the member record
  - Verification of Identification Exceptions

Verifying Eligibility

- The Medi-Cal program verifies member eligibility
  - Verify eligibility and current Share of Cost (SOC) information
- The Point of Service (POS) Network is available 22 hours a day, 7 days a week
- By touch-tone telephone **800-456-2387**
  - Automated Eligibility Verification System (AEVS)
  - Then enter the assigned 6-digit PIN
- By internet access www.medi-cal.ca.gov
  - Enter the billing provider number and 6-digit PIN
  - Place printout in the member record

Request Access to the Eligibility Website

- Providers must have a POS Network/Internet Agreement on file to access the eligibility website
- The POS Network/Internet Agreement can be attained from:
  - Medi-Cal website: www.medi-cal.ca.gov

Verifying Eligibility

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.

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. AEVS is accessible 22 hours a day, 7 days a week. The toll-free number to access AEVS is (800) 456-AEVS (2387). Refer to the Provider Handbook Section 4 (Treating Members) for more information.

Internet Access

The Medi-Cal website 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.

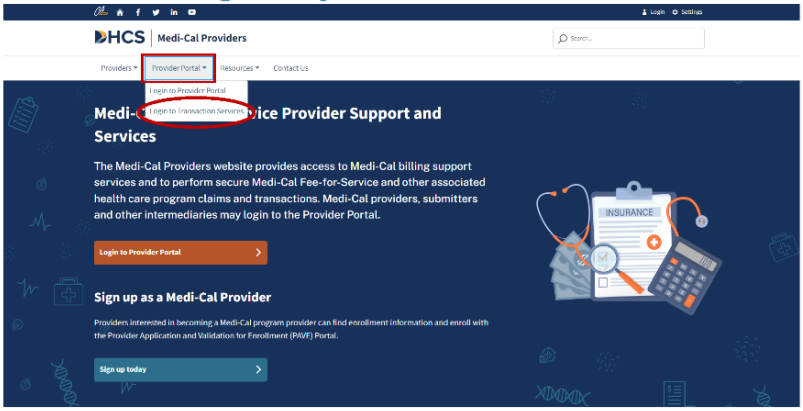
Custom Applications

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.

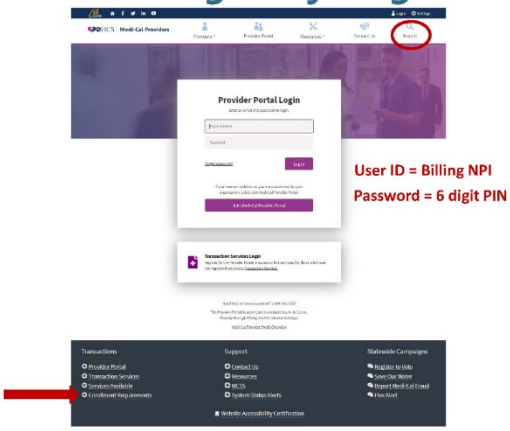
Eligibility Verification Confirmation (EVC)

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).

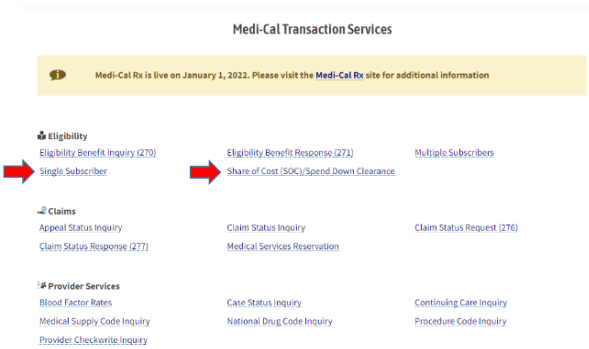
Web Eligibility: Transaction Services



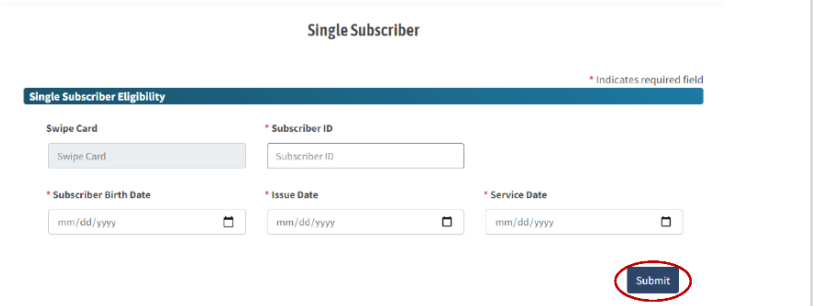
Web Eligibility: Login



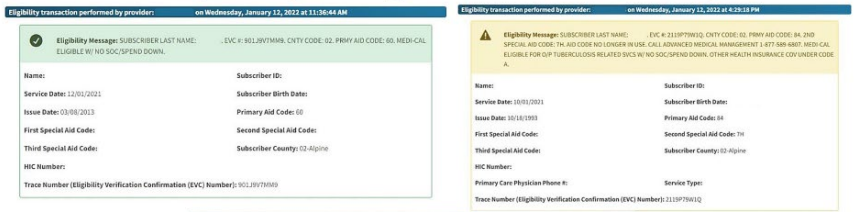
Web Eligibility: Single Subscriber



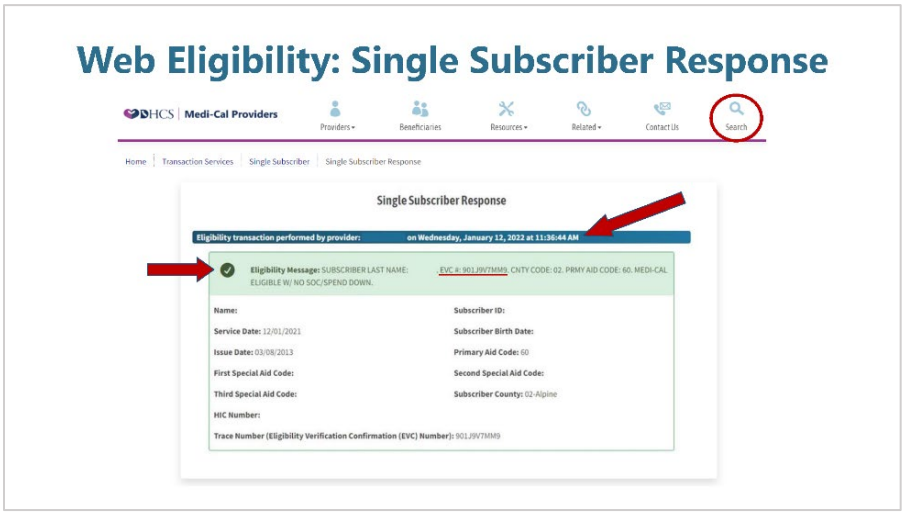
Web Eligibility: Single Subscriber



Web Eligibility: Single Subscriber Response

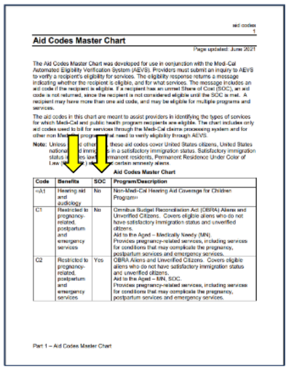


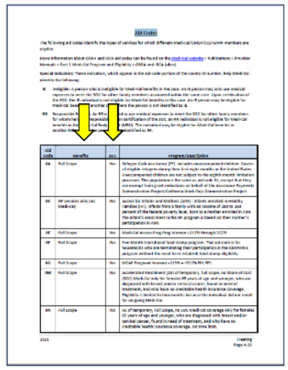
Web Eligibility: Single Subscriber Response



Aid Code Master Chart

» The Aid Code Master Chart lists each Aid Code with columns for:
- Type of Benefits
- Share of Cost

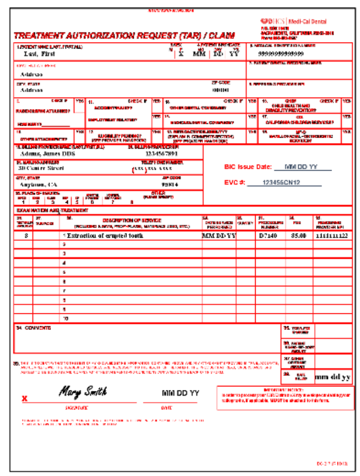




See the Provider Handbook Section 4 or the Medi-Cal website for the Aid Code Master Chart.

Aid Codes

» Not everyone receiving Medi-Cal has full-scope benefits:
- Limited Services
- Restricted Services



Emergency Services

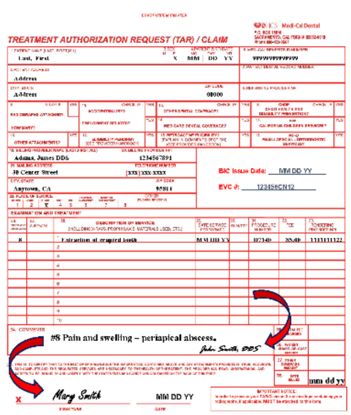
Emergency Services require:

» Emergency Certification Statement

» Two signatures

Emergency services aid codes for OBRA members:

» Must contain specific emergency procedures, regardless of age.



See the Provider Handbook Section 10 (CDT 23 Tables) for a list of allowable procedure codes.

Managed Care Plans

» Patient 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.	
Subscriber Name: LAST, FIRST M.	**Subscriber ID:** 90000000A
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:**
Responsible County: 19 – Los Angeles	**Medicare ID:** XXXXXXXXXX
Primary Care Physician Phone:	**Service Type:**
Service Date: MM/DD/YYYY	**Trace Number (Eligibility Verification Confirmation (EVC) Number:** OOOOOAKEOR

Other Insurance 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# OOOOOAKEOR. 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. COMPDVR.	
Subscriber Name: LAST, FIRST M.	**Subscriber ID:** 90000000A
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:**
Responsible County: 11– Glenn	**Medicare ID:** XXXXXXXXXX
Primary Care Physician Phone:	**Service Type:**
Service Date: MM/DD/YYYY	**Trace Number (Eligibility Verification Confirmation (EVC) Number:** OOOOOAKEOR

Share of Cost (SOC)

» Share of cost is a preset dollar amount that is determined by DHCS for an individual or for a family

- This amount must be met each month before the member is eligible for Medi-Cal benefits
- Any health care services, including non-covered services, may be used to meet SOC

» Only update SOC for services that are performed in your dental office

» Payment for the SOC is based on the provider office policy and the member

See the Provider Handbook Section 4 (Treating Members) for more information.

Case Numbers

- Case numbers indicate the member is part of a family SOC
- SOC Case Summary Report
  - Provided by the member's social worker or local county office
  - Indicates all family members involved
- Benefits may not be received by all in SOC
- No Eligibility Aid Codes:
  - IE – Ineligible
  - OO – No Aid Code
  - RR – Responsible Relative

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: Member share of cost is $87.00

Description	Date of Service	Procedure Code	UCR Fee	Member 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	Section 4 Provider Handbook
Full Scope aid code ▪ Child (under 21) ▪ Adult (21 and over) ▪ Member resides in an ICF or SNF ▪ DDS Member	X	
Emergency/Pregnancy aid code ▪ All ages ▪ 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 and ICF-DDN

- These members are eligible for additional services
- Services do not have to be provided in the facility to be payable
- All services provided in a SNF or ICF require prior authorization except for diagnostic services and emergency procedures
- Not all facilities qualify; therefore, use the website to confirm the classification and licensing of a facility:

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

California Advancing and Innovation Medi-Cal: CalAIM

CalAIM: Overview

- 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, and program and payment reform across the Medi-Cal program
- The major components of CalAIM were the successful outcomes of various pilots through the Dental Transformation Initiative (DTI)
- All FFS claims will be processed and paid in accordance with the Manual of Criteria (MOC) and the Schedule of Maximum Allowances (SMA)
- Effective January 1, 2022

CalAIM: Three Oral Health Initiatives

- Preventative Services: Pay for Performance (P4P)
- Caries Risk Assessment and Silver Diamine Fluoride Benefits
- Continuity of Care: Pay for Performance (P4P)

Preventative Services: Pay for Performance (P4P)

- P4P to increase statewide utilization of preventive services
- Performance payments will be included in the weekly check write 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

B-PRL-TRN-011.T

Caries Risk Assessment (CRA)

- CRA bundle includes the allowable increased frequencies for moderate and high-risk CRA bundles as a statewide dental benefit in alignment with national dental care standards
- To receive payment for the 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
  - Providers with an active status that have completed an attestation form and TYKE training during DTI domain 2 are not required to complete these again

Caries Risk Assessment (CRA) Bundle

- CRA bundles are based on the risk level associated with each Medi-Cal member, ages 0-6 only
- Bundle includes:
  - Caries Risk Assessment: D0601,D0602,D0603 ($15.00)
  - Nutritional counseling: D1310 ($46.00)
- Additional services such as cleaning, fluoride, and exam can be rendered based on the risk level

CalAIM Benefit: 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

Silver Diamine Fluoride (SDF)

- SDF as a statewide dental benefit in alignment with the national dental care standards
- 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
  - Paid $12.00 per tooth

CalAIM Benefit: D1354 Caries Arresting Medicament

- D1354 is a benefit once every 180 days, up to ten teeth per visit, for a maximum of four treatments per tooth, and requires a tooth code.
- For members under age 7 a photograph is required
  - Flexibilities allowed for members under age 4 (per SB 1403)
- Members age 7 or older:
  - Current intraoral photograph and
  - Current diagnostic periapical radiograph and
  - Must document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal

Continuity of Care: Pay for Performance (P4P)

- This P4P payment offers a flat rate payment to dental provider service office locations that maintain dental continuity of care by:
  - Performing 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
  - Payment included in the weekly check write
- 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 2022	CALENDAR YEAR 2023
D0120, D0145, D0150	X	X

Continuity of Care: Dental Codes

Service office locations are eligible to earn performance payments using any of the specified codes below:

» On one service performed annually

» 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 for CalAIM

Department of Health Care Services CalAim Dental Initiative:
https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx

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

Questions about CalAIM?

- Email DHCS: dental@dhcs.ca.gov

Claims Processing Flow Chart

Enrollment

- Enrolls providers into program

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

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

Provider Forms

Provider Forms: TAR/Claim, NOA, RTD, EOB

- Use only these Medi-Cal Dental forms to bill or send prior authorization to the program
- All forms and envelopes are free of charge
  - Re-order through the program's form supplier
- Best Practices:
  - Do Not: make copies, puncture holes, or use stamp signatures
  - Do: use only live signatures and make sure alignment is correct

Contact the Customer Service Center 800-423-0507 for a reprint of a document.

Radiographs and Photographs

- Radiographs and photographs will not be returned to providers
  - Send only duplicate x-rays or paper copies
- They must be single sided
- Nothing on the back
- Make sure it is clear and legible
- Staple to the appropriate claim or authorization on the top left-hand corner

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.

Only Medi-Cal Dental specific, State-approved forms are accepted by Medi-Cal Dental. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Medi-Cal dental covered services. 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 Provider Handbook Section 6 (Forms) contains detailed, step-by-step instructions for completing each of the Medi-Cal Dental forms. The handbook also provides a handy Do and Do Not list 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	5. Written Correspondence
2. RTD	6. Enrollment Forms
3. CIF	7. Telephone Inquiry
4. MC177	8. NOA

The Treatment Authorization Request (Tar)/Claim Form

The TAR/Claim form is used to request authorization of proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Medi-Cal Dental. 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.

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed. 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:

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

Treatment Authorization Request (TAR) Sample

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.): Last, First	3. SEX M: x F:	4. PATIENT BIRTHDATE MO: mm DAY: dd YR: yy	5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999
6. PATIENT ADDRESS: Address			7. PATIENT DENTAL RECORD NUMBER:
CITY, STATE: Address	ZIP CODE: 00000		8. REFERRING PROVIDER NPI:

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY? 9	YES X	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	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.): Adams, James DDS	20. BILLING PROVIDER NPI: 1234567891
21. MAILING ADDRESS: 30 Center Street	TELEPHONE NUMBER: (xxx) xxx-xxxx
CITY, STATE: Anytown, CA	ZIP CODE: 95814

22. PLACE OF SERVICE: OFFICE 1 X; HOME 2; CLINIC 3; SNF 4; ICF 5; HOSPITAL IN-PATIENT 6; HOSPITAL OUT-PATIENT 7; OTHER (PLEASE SPECIFY) 8

BIC Issue Date: _____

EVC #: _____

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.

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)

Claim Form Sample

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?	YES	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF	YES
	X	EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE:	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
HOW MANY? 3							
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: X (OFFICE 1 | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL INPATIENT 6 | HOSPITAL OUT PATIENT 7 | OTHER (PLEASE SPECIFY) 8)

EXAMINATION AND TREATMENT

26. TOOTH/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.

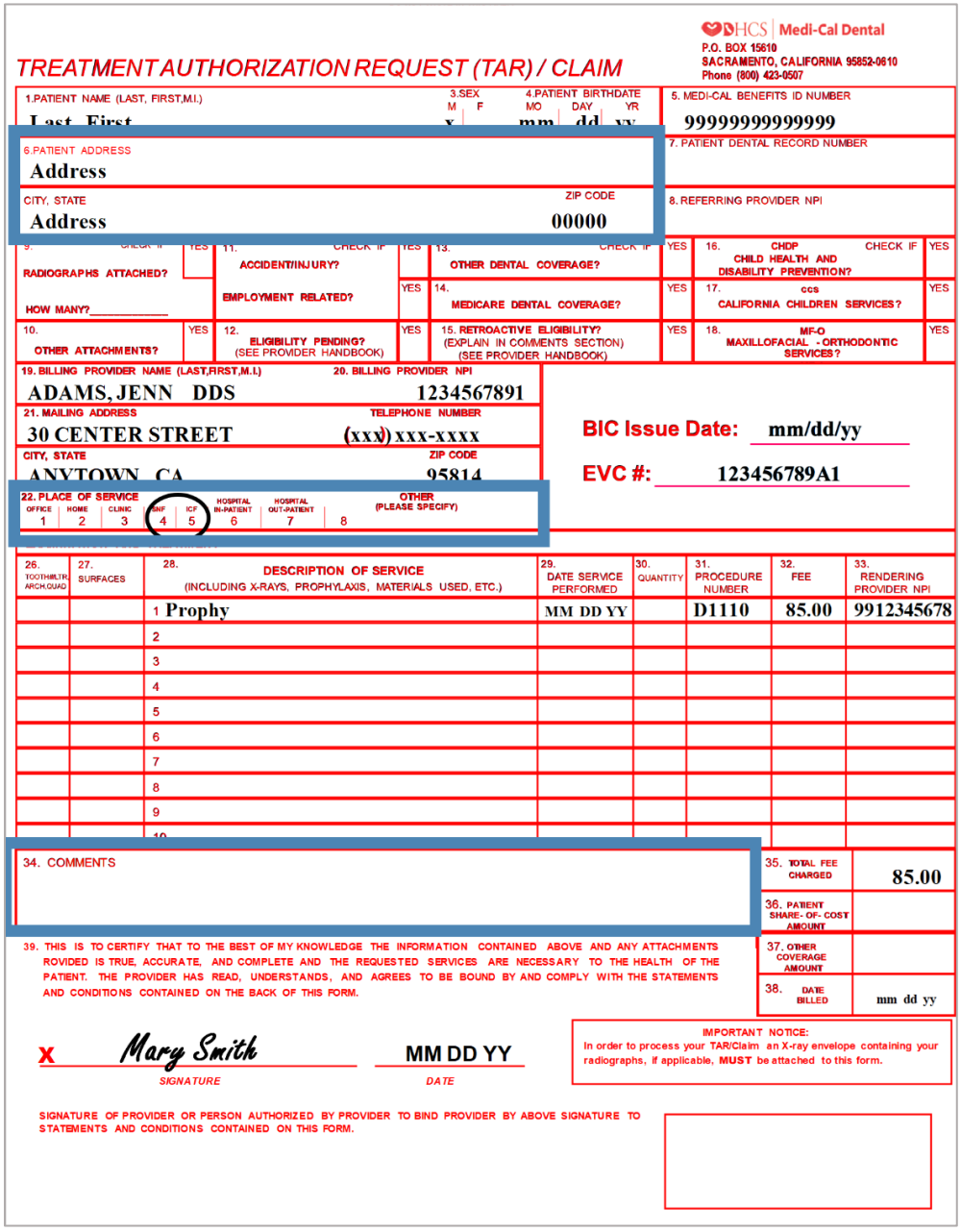
X _____ SIGNATURE _____ DATE

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

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

DC-217 (R 10/19)

Example of a Facility Claim Form



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.): Last First | 3.SEX M F: x | 4.PATIENT BIRTHDATE MO DAY YR: mm dd yy | 5. MEDI-CAL BENEFITS ID NUMBER: 99999999999999

6.PATIENT ADDRESS: Address | 7. PATIENT DENTAL RECORD NUMBER

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

9. RADIOGRAPHS ATTACHED? YES — HOW MANY?_____
11. ACCIDENT/INJURY? YES — EMPLOYMENT RELATED? YES
13. OTHER DENTAL COVERAGE? YES
16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF 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.): ADAMS, JENN DDS | 20. BILLING PROVIDER NPI: 1234567891

21. MAILING ADDRESS: 30 CENTER STREET | TELEPHONE NUMBER: (xxx) xxx-xxxx

CITY, STATE: ANYTOWN CA | ZIP CODE: 95814

BIC Issue Date: mm/dd/yy

EVC #: 123456789A1

22. PLACE OF SERVICE: OFFICE 1 | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

26. TOOTH/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

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.

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.

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

Box 6: Member address = Facility's address

Box 22: Check #4 or #5 regardless of where the member is being treated

Box 34: Comment Box:

- Facility name and phone number
- If treating patients outside of the facility, indicate in box 34 where the patient is actually being treated, i.e., office, hospital

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. 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.
7. If dated services are submitted on a request for authorization, they will not be paid until the authorized services are paid.
8. Medi-Cal Dental's evaluation of TARs and Claims will be more accurate when narrative documentation is included. Use Field 34 for any narrative documentation.
    a. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
    b. Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form
    c. If submitting electronically, abbreviate comments to make optimum use of allotted space.

Billing Limitations

The Medi-Cal Dental program will consider payment for dated services based on the Schedule of Maximum Allowance (SMA) if the form is received:

Payment % of SMA	Time Frame
100%	Within 6 months of the date of service
75%	Within 7 to 9 months of the date of service
50%	Within 10 to 12 months of the date of service
0	After 12 months from the date of service

» Payment is ALWAYS subject to member eligibility

The Notice of Authorization (NOA)

The NOA is a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization. The Medi-Cal Dental program will indicate on the NOA whether the requested services are allowed, modified, or disallowed. Subsequently, 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 Provider Handbook)

Note: *Prior to completing the form, verify the information printed is correct.*

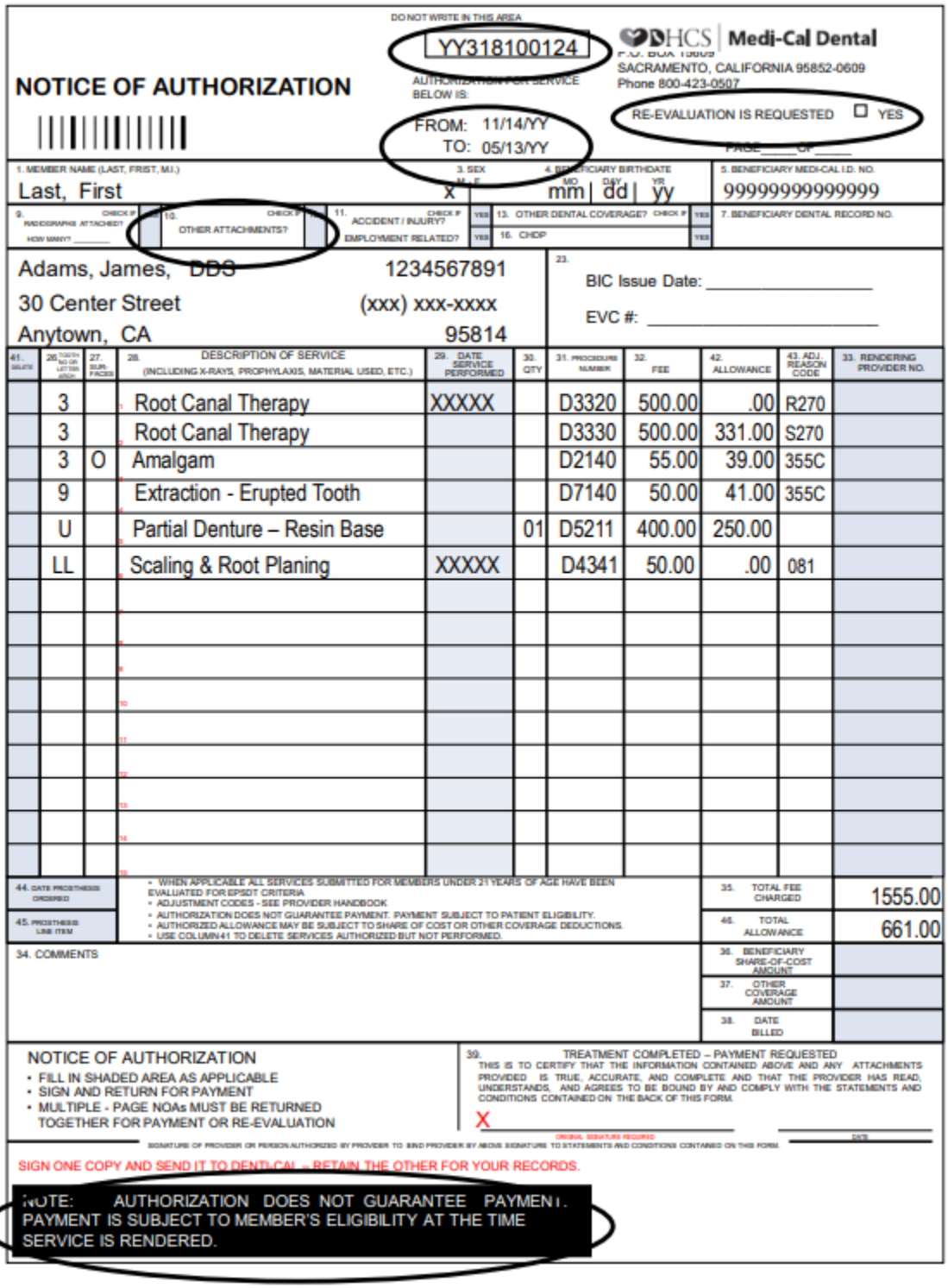
The NOA has a statement printed on the bottom of the form that reads: “NOTE: Authorization does not guarantee payment. Payment subject to member's eligibility.” This statement has been added to remind providers to verify the member's eligibility prior to providing services.

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.

Notice of Authorization (NOA) Sample



DO NOT WRITE IN THIS AREA

YY318100124

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, FRST, MI.)	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? HOW MANY?	10. OTHER ATTACHMENTS?	11. ACCIDENT / INJURY? EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE?	16. CHDP	7. BENEFICIARY DENTAL RECORD NO.
			YES	YES	

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	27. SURFACES	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
40. 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.

NOA 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:

   Medi-Cal Dental

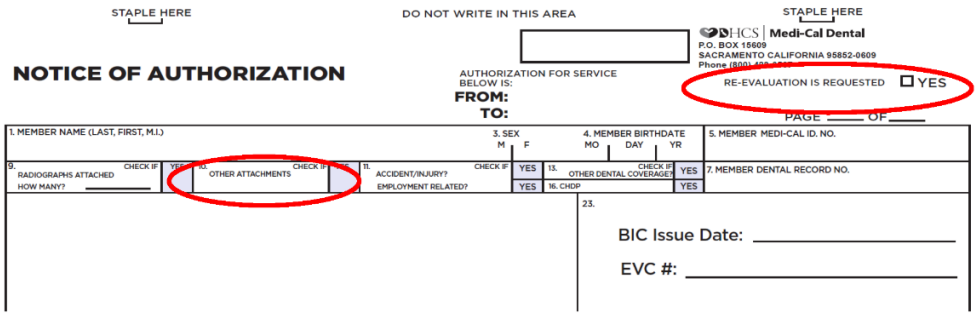
   P.O. Box 15609

   Sacramento, CA 95852-0609

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

If a denial is upheld and another review is wanted, a new TAR must be submitted.

Re-evaluation Request



- 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

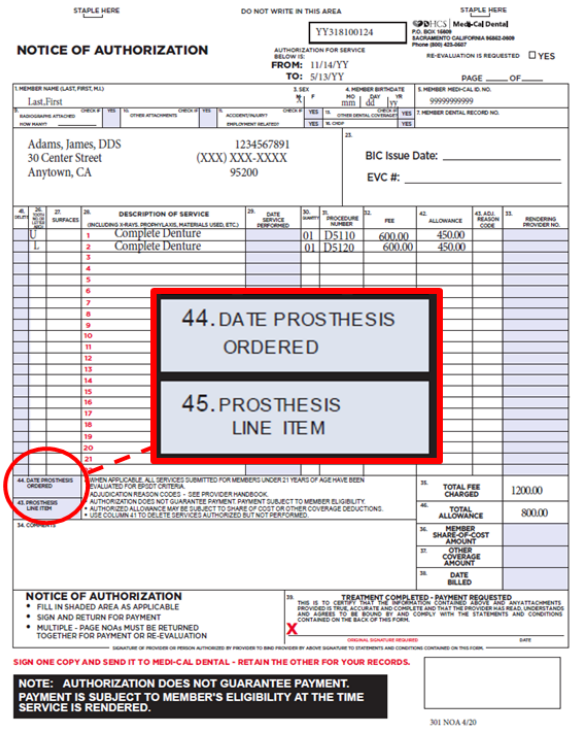
NOA Helpful Hints/Reminders

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.

Note: *Authorization does not guarantee payment. Payment is subject to a member's eligibility. Refer to the Provider Handbook Section 6 (Forms) for more information.*

NOA Hints and Reminders

- Altered Treatment Plan
- Lab Order Date
- Undeliverable Appliance
- Billing Limitations



Resubmission Turnaround Document (RTD)

An RTD is a computer-generated form used by Medi-Cal Dental to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The RTD is divided into two sections: Section “A” and Section “B”.

Section “A” notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section “A” is assigned a letter of the alphabet under “field.” Section “A” is kept by the provider for office records. Section “A” also indicates the return due date. The provider has 45 days to respond to the RTD.

Section “B” is the corrected information filled in by the provider. This section is returned to Medi-Cal Dental.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

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

1. 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.
2. Return all pages of a multi-page RTD in one envelope.
3. 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.
4. Return the RTD to:

   Medi-Cal Dental

   PO Box 15609

   Sacramento, CA 95852-0609

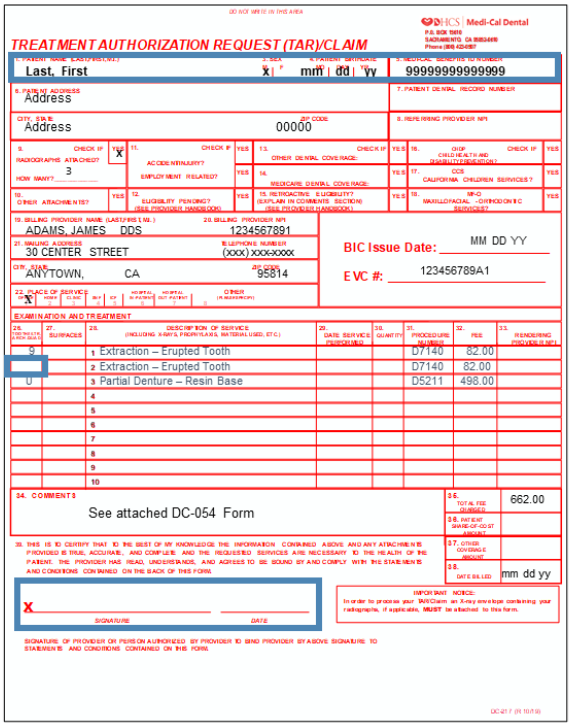
Upon receipt of the RTD, Medi-Cal Dental matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

Note: *If the RTD is not returned within the 45-day time limitation, the TAR, Claim or NOA will be denied according to Medi-Cal Dental policies.*

Refer to the Provider Handbook Section 6 (Forms) for more information.

» Example of why an RTD might be sent to your office:

- Mismatched member information
- Missing tooth code
- Missing live signature



DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
P.O. BOX 15616
SACRAMENTO, CA 95852-0616
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

4. PATIENT NAME (LAST,FIRST,MI.)	5. SEX	6. PATIENT BIRTHDATE	7. MEDICAL BENEFITS ID NUMBER
Last, First	X F	mm dd yy	99999999999999

8. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
Address	

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

9. CHECK IF RADIOGRAPHS ATTACHED?	YES X	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE:	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION?	CHECK IF YES
HOW MANY? 3			YES	14. MEDICARE DENTAL COVERAGE:	YES	17. DOE 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. MP-O MAXILLOFACIAL - ORTHODONTIC PROVIDER?	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 X | HOME | CLINIC | SNF | ICF | HOSPITAL (IN PATIENT) | HOSPITAL (OUT PATIENT) | OTHER (IN ADDITION)

EXAMINATION AND TREATMENT

25. TOOTH NO. (USE NUMBERS SHOWN ON CHART)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROSTHESIS, MATERIAL USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER'S NPI
9		1 Extraction – Erupted Tooth			D7140	82.00	
		2 Extraction – Erupted Tooth			D7140	82.00	
0		3 Partial Denture – Resin Base			D5211	498.00	
		4					
		5					
		6					
		7					
		8					
		9					
		10					

34. COMMENTS: See attached DC-054 Form

36. TOTAL FEE SUBMITTED	662.00
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 THIS STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

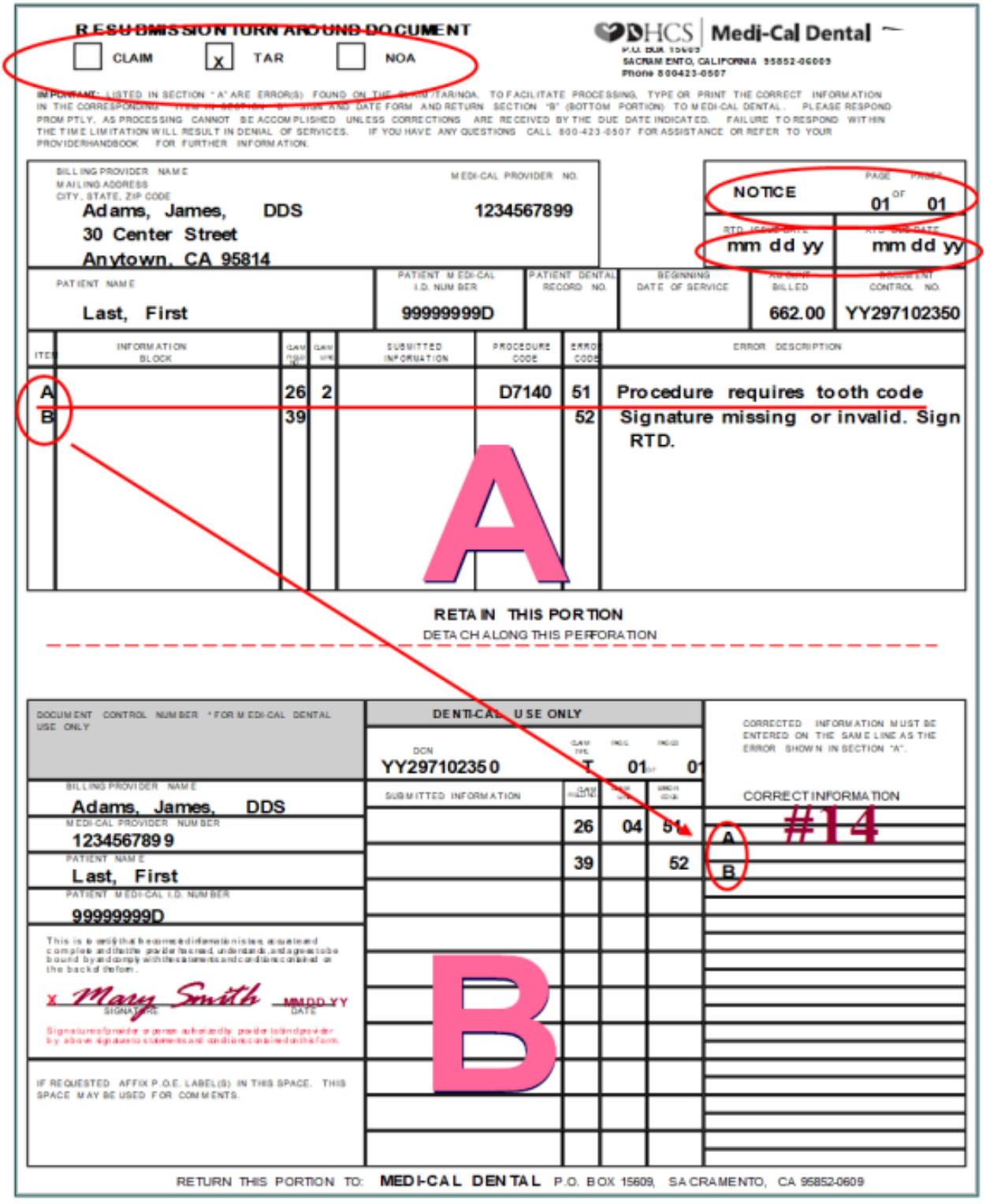
X _____ SIGNATURE _____ DATE

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-421 F (R 10/19)

Resubmission Turnaround Document Sample



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 AREA(S) IN SECTION "B" 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
Adams, James, DDS
30 Center Street
Anytown, CA 95814

MEDI-CAL PROVIDER NO.
1234567899

NOTICE
PAGE 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 TYPE	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 YY297102350
CLAIM TYPE T
PROC 01
PROC 01

BILLING PROVIDER NAME
Adams, James, DDS

MEDI-CAL PROVIDER NUMBER
1234567899

PATIENT NAME
Last, First

PATIENT MEDI-CAL I.D. NUMBER
99999999D

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.

SUBMITTED INFORMATION	CLAIM TYPE	PROC	PROC
	26	04	51
	39		52

B

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

	CORRECT INFORMATION
A	#14
B	

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

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.

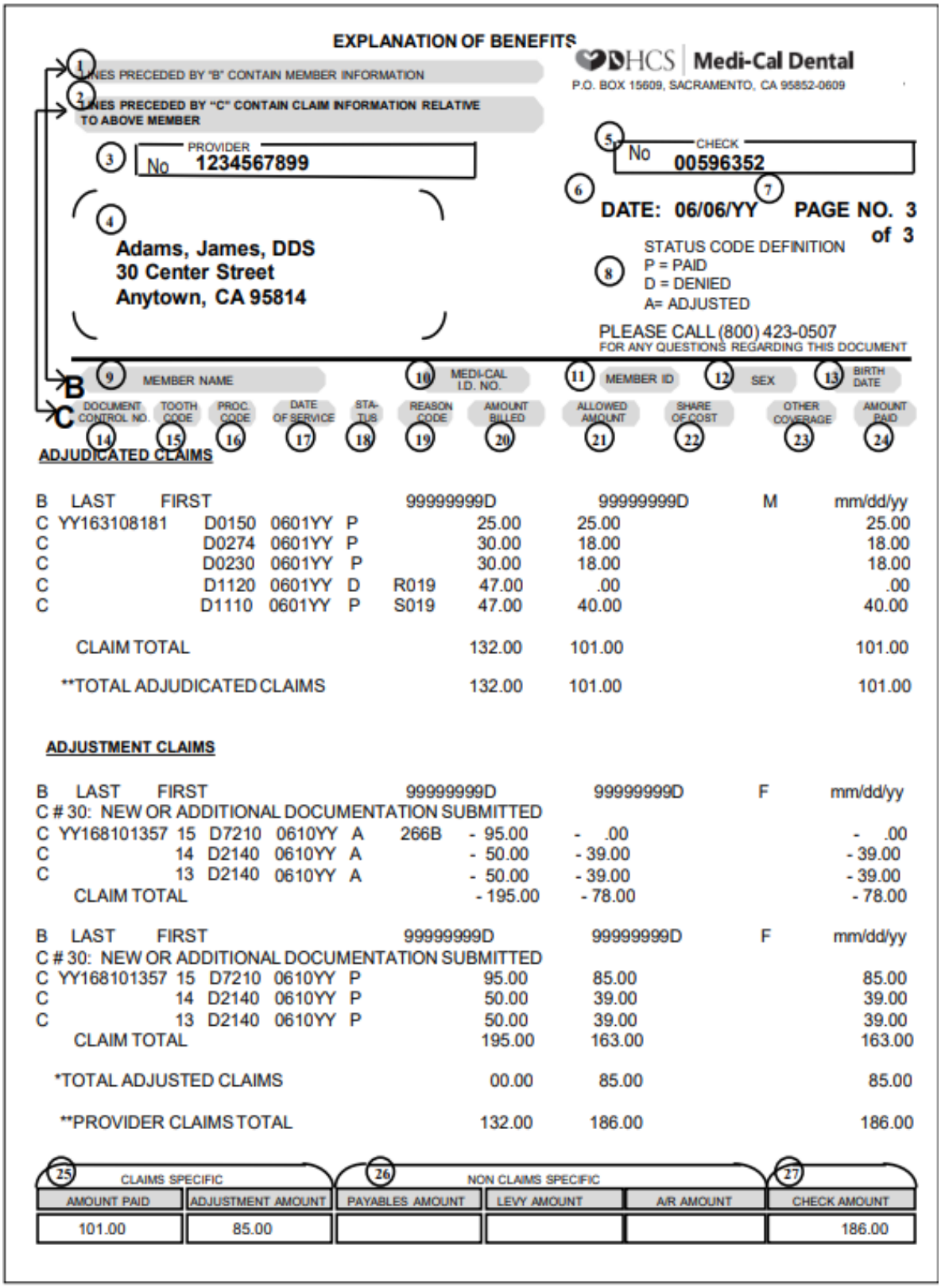
Following is an explanation of each item shown on the sample EOB:

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 that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of 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. The reason codes and a written explanation of each one are printed on the EOB.
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 Schedule of Maximum Allowances (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.

Refer to the Provider Handbook Section 6 (Forms) for more information.

Explanation of Benefits (EOB) Sample



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 7 DATE: 06/06/YY 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

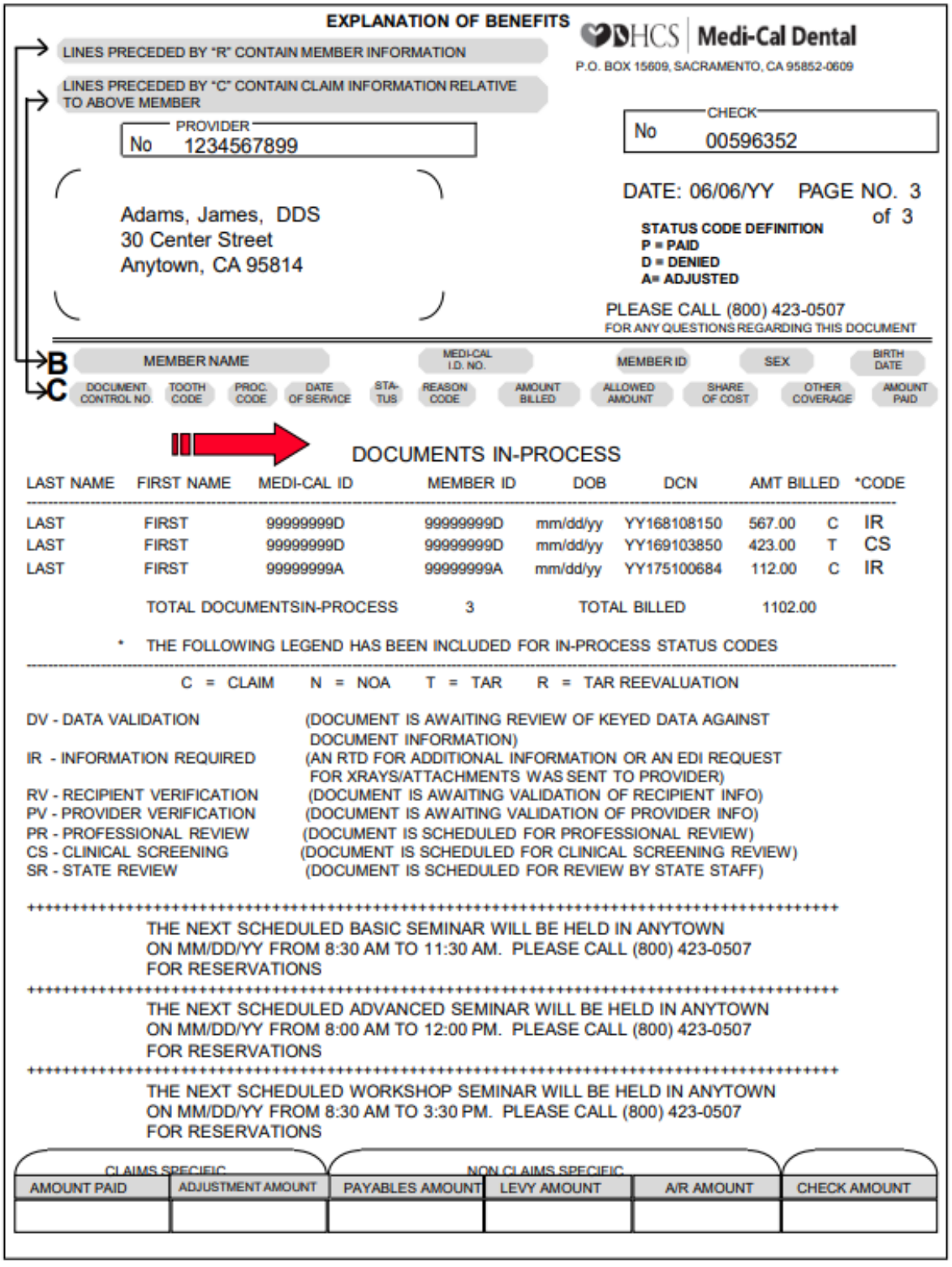
B	LAST	FIRST				99999999D		99999999D		M	mm/dd/yy
C	YY163108181		D0150	0601YY	P		25.00	25.00			25.00
C			D0274	0601YY	P		30.00	18.00			18.00
C			D0230	0601YY	P		30.00	18.00			18.00
C			D1120	0601YY	D	R019	47.00	.00			.00
C			D1110	0601YY	P	S019	47.00	40.00			40.00
	CLAIM TOTAL						132.00	101.00			101.00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

EOB Documents in Process Sample



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)

++

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

++

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

++

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

Claim Inquiry Forms (CIF)

Submitting a Claim Inquiry Form (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

A CIF tracer is used to request the status of a TAR or claim. 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 Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Reevaluation

A CIF claim re-evaluation is used to request the reevaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the “Adjusted Claims” section.

Claim re-evaluations must be received within 6 months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

To submit a CIF to Medi-Cal Dental, 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:

   Medi-Cal Dental
   PO Box 15609
   Sacramento, CA 95852-0609

Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Customer Service Center at (800) 423-0507

All radiographs/photos submitted with a CIF must be stapled to the back of the corresponding CIF.

Refer to the Provider Handbook Section 6 (Forms) for more information.

Claim Inquiry Response (CIR)

Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Medi-Cal Dental will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- Member name
- Member Medi-Cal identification number
- Member Dental Record or account number, if applicable
- Document Control Number of the original document
- The date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY" will contain a status code and a typed explanation of that code. Refer to the Provider Handbook Section 7 (Codes) for more information.

Claim Inquiry Form – Tracer Sample

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 the Medi-Cal Dental

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 ID 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:

☒ Claim for Payment. Attach a copy of form
Date of Service *MM DDYY*.

☐ 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 *Jane 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.

FOR MEDICAL DENTAL USE ONLY

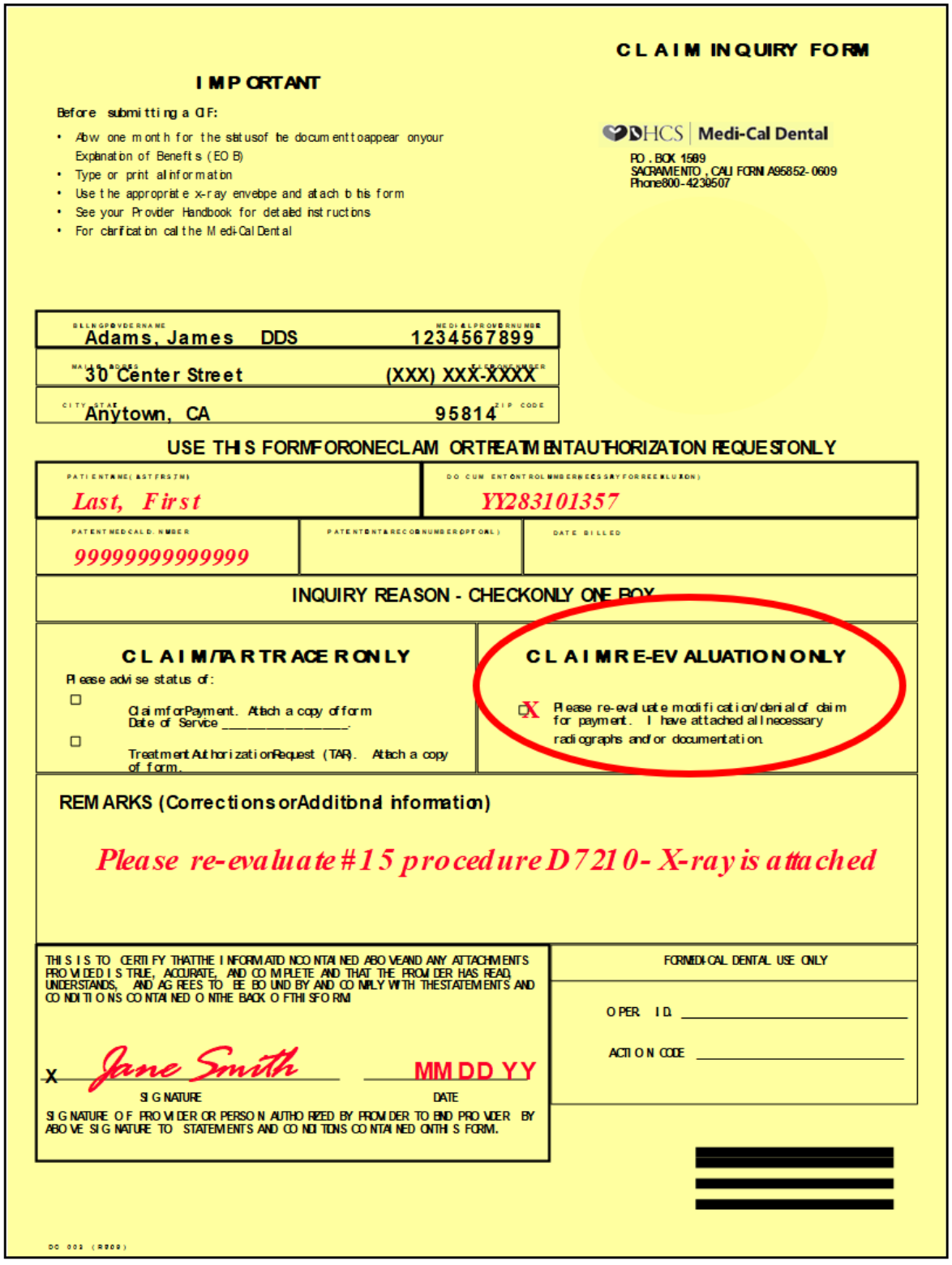
OPER. I.D. _____

ACTION CODE _____

[redacted]

DC 002 (R 07/09)

Claim Inquiry Form – Re-evaluation Sample



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 the Medi-Cal Dental

DHCS | Medi-Cal Dental
P.O. BOX 1589
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME: Adams, James DDS
MEDI-CAL PROVIDER NUMBER: 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): Last, First
DOCUMENT CONTROL NUMBER (NECESSARY FOR CORRECTION): YY283101357
PATIENT MEDI-CAL ID. NUMBER: 99999999999999
PATIENT DENTAL RECORD NUMBER (OPTIONAL):
DATE BILLED:

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 is attached

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 Jane 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.

FOR MEDI-CAL DENTAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R809)

Claim Inquiry Response Sample

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

[illegible]
P.O.BOX [illegible]
SACRAMENTO, CALIFORNIA 95812
Phone (800) [illegible]

PATIENT NAME: Last, First
DOCUMENT CONTROL NO:
PATIENT MEDI-CAL ID NO.: 99999999D
PATIENT DENTAL RECORD NUMBER:
DATE RECEIVED: 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

The Provider Appeals Process

First Level Appeals

» Submit appeal within 90 days:

- Use letterhead not a CIF
- Letter must specifically request a 1st Level Appeal
- Send all information/copies to uphold the request
- Send Appeals directly to the Appeals address
- Office will receive written notification from the Medi-Cal Dental program within 21 days

» Last recourse with the Medi-Cal Dental Program

First Level Appeals

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 provider must submit the appeal by letter to Medi-Cal Dental within 90 days of the EOB denial date. Do not use CIFs for this purpose.
2. The letter must specifically request a first-level appeal.
3. Send all information and copies to justify the request. Include all documentation and radiographs.
4. The appeal should clearly identify the claim or TAR involved and describe the disputed action.
5. First-level appeals should be directed to:

   Medi-Cal Dental
   Attn: Provider First-Level Appeals
   PO Box 13898
   Sacramento, CA 95853-4898

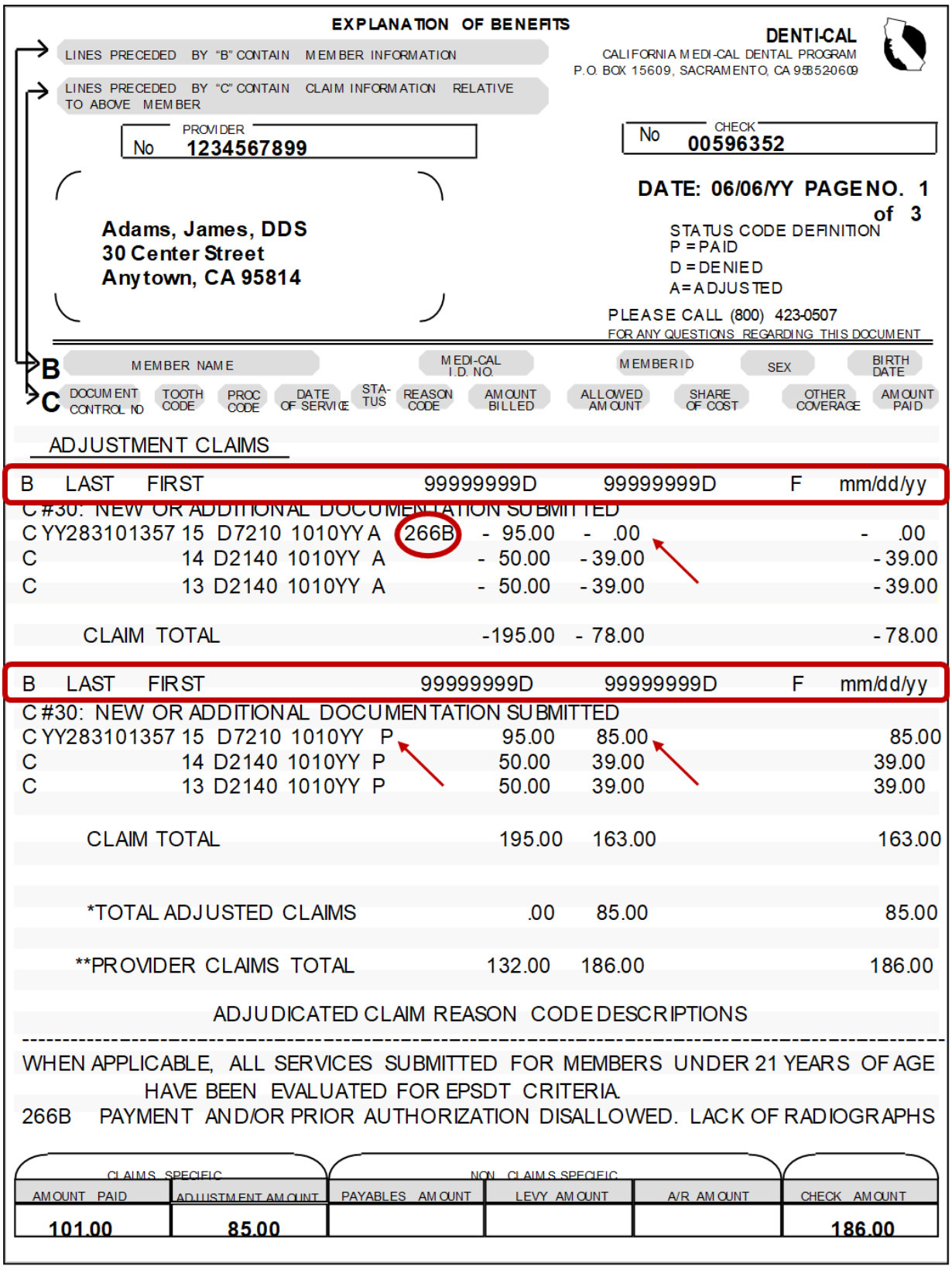
The Medi-Cal Dental staff (including professional review if necessary) will review the appeal and respond in writing if the denial is upheld.

The provider should keep copies of all documents related to the first-level appeal.

Judicial Remedy

Under Title 22 regulations, a Medi-Cal Dental provider who is dissatisfied with the first-level 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 of the First Level Appeal.

EOB Adjustment Claims Sample



EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" 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. 1 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

ADJUSTMENT CLAIMS

B	LAST	FIRST				99999999D	99999999D	F	mm/dd/yy		
C	#30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	YY283101357	15	D7210	1010YY	A	266B	- 95.00	- .00			- .00
C		14	D2140	1010YY	A		- 50.00	- 39.00			- 39.00
C		13	D2140	1010YY	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	YY283101357	15	D7210	1010YY	P		95.00	85.00			85.00
C		14	D2140	1010YY	P		50.00	39.00			39.00
C		13	D2140	1010YY	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

ADJUDICATED CLAIM REASON CODE DESCRIPTIONS

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

Electronic Data Interchange

Electronic Data Interchange (EDI)

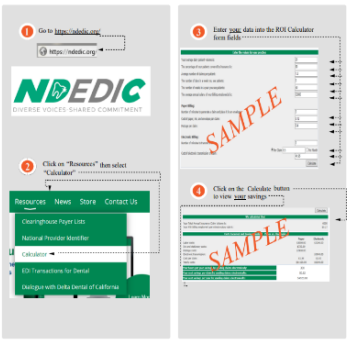
- EDI is the way that claims are submitted to Medi-Cal Dental electronically
- EDI claims are processed an average of five days faster than paper claims
- Over 70% of Medi-Cal Dental incoming documents are received electronically
- Claims, TARs, and NOAs can all be processed electronically

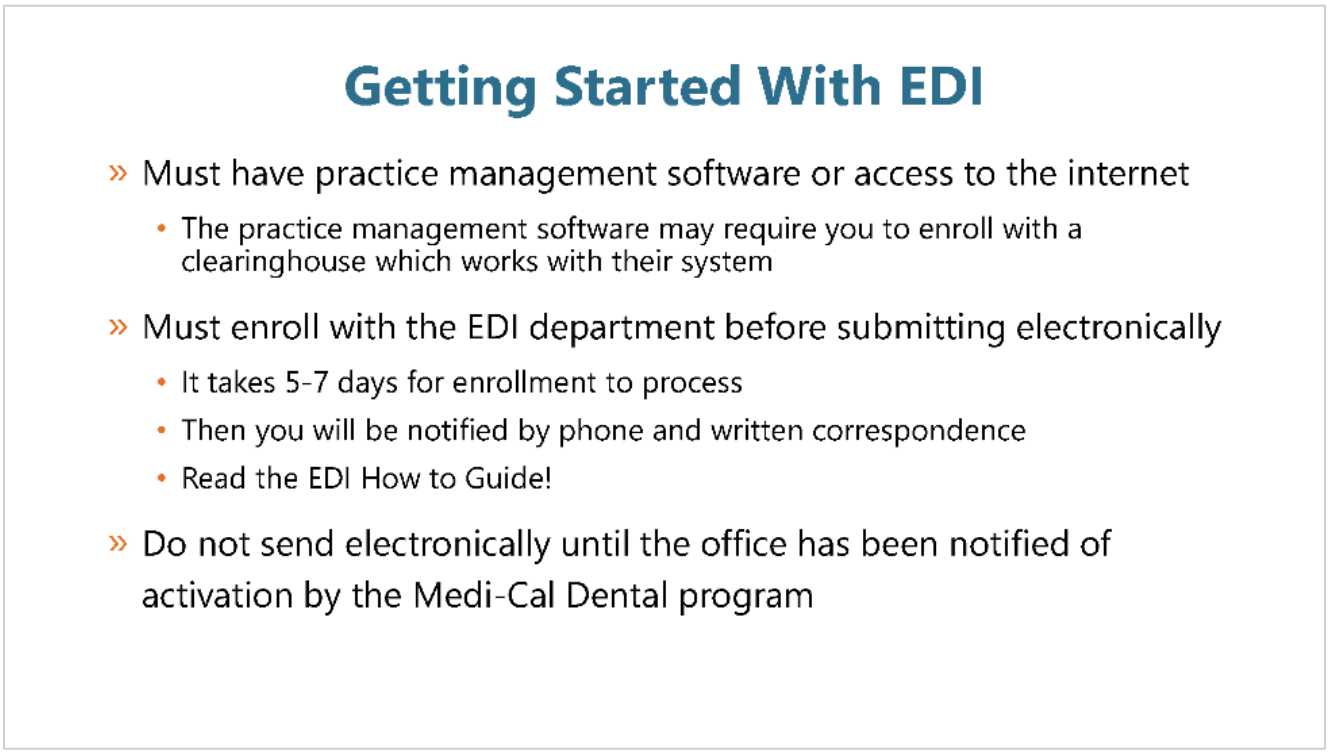
Benefits of Using EDI

- Maximize computer capabilities
- Make billing simpler
- Have fewer rejections
- Have tracking capabilities
- Receive payment faster
- Saves Money!

EDI Savings Calculator

- From the website: www.ndedic.org
- Click on the 'Resources' Tab and select the 'Calculator'
- Enter your data
- Click 'Calculate' to see your savings





EDI Support

For additional EDI information and support please contact:

- 800-423-0507
- medi-caldentaledi@gainwelltechnologies.com

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.

Adjudication Reason Codes

ARC #	Adjudication Reason Code Description
Diagnostic/Preventive	
001	Procedure is a benefit once per patient, per provider.
001A	An orthodontic evaluation is a benefit only once per patient, per provider.
002	Procedure is a benefit once in a six-month period for patients under age 21.
002A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for members under age 21 or does not meet CRA criteria.
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.
004A	Procedure D1320 is only a benefit when billed on the same date of service as procedure D0150 or D0120 to the same provider.
006	Procedure is a benefit once per tooth.
008	Procedure was not adequately documented.
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.
010	Procedure 020 not a benefit in conjunction with Procedure 030.
011	Procedure 030 is payable only once for a visit to a single facility or other address per day regardless of the number of patients seen.
011A	Procedure 030 is payable only when other specific services are rendered same date of service.
012	Procedure 030, time of day, must be indicated for office visit.
012A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030
013	Procedure requires an operative report or anesthesia record with the actual time indicated.
013A	Procedure has been authorized. However, the actual fee allowance cannot be established until payment is requested with the hospital time documented in operating room report.
013B	Procedure D9410 is not payable when the treatment is performed in the provider's office or provider owned ambulatory surgical center.
013C	The anesthesia record must be signed by the rendering provider and the rendering provider's name and permit number must be printed and legible.
013D	The treating provider name on the anesthesia record does not coincide with the Rendering Provider Number (NPI) in field 33 on the claim.
013E	The treating provider performing the analgesia procedure must have a valid permit from the DBC and the permit number must be on file with Denti-Cal.
014	Procedure is not a benefit to an assistant surgeon.

ARC #	Adjudication Reason Code Description
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
020A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
020B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
020C	Prophy and fluoride procedures are allowable once in a six month period.
020D	Prophy and fluoride procedures are allowable once in a 12 month period.
020E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
020F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
020G	Topical application of fluoride is payable only for caries control.
020H	Prophy and fluoride procedures are allowable once in a 4-month period when the patient resides in an intermediate care facility (ICF) or a skilled nursing facility (SNF) that is licensed pursuant to health and safety code (H&S code) section 1250-1264.
020I	Patients under age 6, fluoride procedures are allowable once in a 4-month period and prophy procedures are allowable once in a 6-month period.
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.
022	Full mouth or panographic X-rays are a benefit once in a three year period.
023	A benefit twice in a six-month period per provider.
024	A benefit once in a 12-month period per provider.
024A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
024B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
024C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
024D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.

ARC #	Adjudication Reason Code Description
024E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
024F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.
027	Procedure is not a benefit for edentulous areas.
028	A benefit once in a six-month period per provider.
028A	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
028B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
029	Payment/Authorization denied due to multiple unmounted radiographs.
029A	Payment/Authorization denied due to undated radiographs or photographs.
029B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.
029C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.
029D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.
029E	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative
029F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.
029G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
029H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.
030	An adjustment has been made for the maximum allowable radiographs.
030A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
030B	Combination of radiographs is equal to a complete series.
030C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.
030D	Periapicals are limited to 20 in any consecutive 12-month period.
031	Procedure is payable only when submitted.

ARC #	Adjudication Reason Code Description
031A	Photographs are a benefit only when appropriate and necessary to document associated treatment.
031B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.
031C	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
031D	Photographs are not payable when the date does not match the date of service on the claim.
032A	Endodontic treatment and postoperative radiographs are not a benefit.
032B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
032C	X-rays disallowed for the following reasons: X-rays appear to be of another person.
032D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.
033A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
034	Emergency procedure cannot be prior authorized.
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
038	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free
039	Dental sealants are only payable when the occlusal surface is included.
039A	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
Oral Surgery	
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
043A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedure(s).
044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
046A	Postoperative visits are not payable after 30 days following the surgical procedure.

ARC #	Adjudication Reason Code Description
047	Postoperative care within 90 days by the same provider is not payable.
047A	Postoperative care within 30 days by the same provider is not payable.
047B	Postoperative care within 24 months by the same provider is not payable.
048	Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
049	Extractions are not payable for deciduous teeth near exfoliation.
050	Surgical extraction procedure has been modified to conform with radiographic appearance.
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
054A	Procedure is not a benefit within six months of extractions in the same quadrant.
054B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.
058	Procedure is a benefit for anterior permanent teeth only.
059	Procedure allowed per Current Procedural Terminology (CPT) code description.
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
Drugs	
063	Only the most profound level of anesthesia is payable per date of service. This procedure is considered global and is included in the fee for the allowed anesthesia procedure.
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.

ARC #	Adjudication Reason Code Description
066	The need for 301 must be justified and documented.
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.
069	Procedure is not a benefit when all additional services are denied or when there are no additional services submitted for the same date of service.
070	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.
071	Intravenous Sedation or General Anesthesia is not deemed medically necessary based on the treatment plan and/or documentation submitted. Please submit additional documentation to justify the medical necessity for IV Sedation/GA or attempt treatment under a less profound sedation modality.
071A	Behavior Modification (D9920) is not payable when sedation is used as a behavior modification modality.
071B	Behavior Modification (D9920) is only payable when the patient is a special needs patient that requires additional time for a dental visit.
071C	Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit.
071D	This procedure does not have a fee in the Schedule of Maximum Allowance and is not payable through a claim submission. Please see https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Dental_Case_Management_Program/ for further instructions.
Periodontics	
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.
073	Periodontal chart not current.
073A	Periodontal chart not current. Older than 14 months.
073B	Periodontal chart not current. Periodontal treatment performed after charting date.
073C	Periodontal chart not current. Charting date missing or illegible.
073D	Periodontal chart not current. Charting date invalid or dated in the future.
073E	Periodontal chart not current. Older than 12 months
074A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.
074B	Periodontal procedure disallowed due to inadequate charting of: Mobility.
074C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.
074D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.

ARC #	Adjudication Reason Code Description
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.
076	A benefit twice in a 12-month period per provider.
077	Periodontal procedures 452, 472, 473, and 474 are not benefits for beneficiaries under 18 years of age except for cases of drug-induced hyperplasia.
077A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.
079	Multiples of Procedure 452 must be performed on different days.
080	A prophy or prophy and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.
081	Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs.
081A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.
083A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.
085A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.
085B	Only one Scaling and Root Planing, or Perio Maintenance or Prophylaxis procedure is allowable within the same calendar quarter.
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
086A	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
086B	Full Mouth Debridement is not payable when rendered within 24 months of a scaling and root planning.
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
087A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
087B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.

ARC #	Adjudication Reason Code Description
088	Procedure is a benefit once per quadrant every 24 months.
088A	Procedure is a benefit once per quadrant every 36 months.
089	Procedure is not a benefit for periodontal grafting.
Endodontics	
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
091A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.
092	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary postoperative care within 90 days.
093A	Endodontic procedure is not payable when root canal filling underfilled.
093B	Endodontic procedure is not payable when root canal filling overfilled.
093C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.
093D	Endodontic procedure is not payable when: Root canal filling is undercondensed.
093E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
093F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
096	Procedure not a benefit in conjunction with a full denture or overdenture.
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
098	Procedures 530 and 531 include retrograde filling.
099	A benefit once per tooth in a six-month period per provider.
100	Procedure is not a benefit for an endodontically treated tooth.
101	This procedure requires a prerequisite procedure.
101A	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.
Restorative	
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.

ARC #	Adjudication Reason Code Description
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
113A	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
113B	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
113C	Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.
113E	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
113F	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a pre-fabricated or laboratory processed crown and the need for the restoration is not justified.
114	Tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures are included in the fee for a completed restorative service.
115	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
116	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspids.
117	Procedure not a benefit for a primary tooth near exfoliation.
118	Proximal restorations in anterior teeth are paid as single surface restorations.
119	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
120	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
121	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
121A	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
122	Tooth does not meet the Manual of Criteria for a prefabricated crown.

ARC #	Adjudication Reason Code Description
123	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
124	Radiograph or photograph indicate additional surface(s) require treatment.
124A	Decay not evident on requested surface(s), but decay evident on other surface(s).
125	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.
125A	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.
125B	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
126	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.
127	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
128	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
131	Procedure is a benefit only in cases of extensive coronal destruction.
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
133	Procedure not allowed due to denial of a root canal filled with silver points.
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed; i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
136	Procedure not a benefit for prefabricated crowns.
Prosthodontics	
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.

ARC #	Adjudication Reason Code Description
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
146	A removable partial denture includes all necessary clasps, rests and teeth.
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
148	Sufficient teeth are present for the balance of the opposing prosthesis.
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
149A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
151	This procedure is not a benefit for a resin base partial denture.
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).
153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.
155	Procedure requires a properly completed prosthetic DC054 form.
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.
157	A laboratory invoice is required for payment.
160	Laboratory or chairside relines are a benefit once in a 12 month period per arch.
161	Procedure 722 is a benefit once in a 12-month period per arch.
161A	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.
161B	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.
162	Patient's existing prosthesis is adequate at this time.
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).
164	Prosthesis serviceable by laboratory reline.

ARC #	Adjudication Reason Code Description
165	Existing prosthesis can be made serviceable by denture duplication (“jump”, “reconstruction”).
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
168A	Patient does not wish extractions or any other dental services at this time.
168B	Patient has selected different provider for treatment.
169	Procedure 723 is limited to two per appliance in a full 12 month period.
169A	Procedure is limited to two per prosthesis in a 36-month period.
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.
172	Payment for a prosthesis is made upon insertion of that prosthesis.
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five year period.
174	Procedure 724 is a benefit only when the existing denture is at least two years old.
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.
175A	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.
176	Per radiographs, insufficient tooth space present for the requested procedure.
177	New prosthesis cannot be authorized. Patient’s dental history shows prosthesis made in recent years has been unsatisfactory for reasons that are not remediable.
178	The procedure submitted is no longer a benefit under the current criteria manual. The procedure allowed is the equivalent to that submitted under the current Schedule of Maximum Allowances and criteria manual.
179	Procedure requires prior authorization and cannot be considered as an emergency condition.
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.
Space Maintainers	
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.
194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.
195	A space maintainer is not a benefit for the upper or lower anterior region.

ARC #	Adjudication Reason Code Description
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.
197	Procedure requested is not a benefit when only one tooth space is involved or qualifies. Maximum benefit has been allowed.
197A	Procedure is only a benefit to maintain the space of a single primary molar.
Orthodontic Services	
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200A	Adjustments of banding and/or appliances are allowable once per quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
Maxillofacial Services	
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12 month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.

ARC #	Adjudication Reason Code Description
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.

ARC #	Adjudication Reason Code Description
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon's provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: "CCS approved" stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.
Miscellaneous	
258	Functional limitations or health condition of the patient preclude(s) requested procedure.
259A	Procedure not a benefit within 6 months to the same provider.
259B	Procedure not a benefit within 12 months to the same provider.
259C	Procedure not a benefit within 36 months to the same provider.
259D	Procedure not a benefit within 24 months to the same provider.
259E	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
260	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
261	Procedure is not a benefit of this program.
261A	Procedure code is missing or is not a valid code.
261B	CDT codes are not valid for this date of service.

ARC #	Adjudication Reason Code Description
261C	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
262	Procedure requested is not a benefit for children.
263	Procedure requested is not a benefit for adults.
264	Procedure requested is not a benefit for primary teeth.
265	Procedure requested is not a benefit for permanent teeth.
266A	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
266B	Payment and/or prior authorization disallowed. Lack of radiographs.
266C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
266D	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
266E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
266F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
266G	Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.
266H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.
266I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
266J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
266K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
266L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
266M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
266N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
266P	Payment and/or prior authorization disallowed. Photographs are required.
267	Documentation not submitted.
267A	Description of service, procedure code and/or documentation are in conflict with each other.
267B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.

ARC #	Adjudication Reason Code Description
267C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.
267D	Documentation insufficient/not submitted. Study models not submitted.
267E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.
267F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
267G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
267H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
267I	Documentation submitted is incomplete.
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
268A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.
268B	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
268C	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate fo a FRADS that may be a covered benefit.
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
269B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
269C	Procedure denied for the following reason: Associated with another denied procedure.
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
271A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
271B	Procedure is disallowed due to the following: Apical radiolucency.
271C	Procedure is disallowed due to the following: Arch lacks integrity.
271D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
271E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
271F	Procedure is disallowed due to the following: Gross destruction of crown or root.
271G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.

ARC #	Adjudication Reason Code Description
271H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
271I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
271J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.
272	Tooth not present on radiograph.
272A	Per radiograph, tooth is unerupted.
272B	Radiographs and/or documentation reveals that tooth number may be incorrect.
273	Procedure denied as beneficiary is returning to original provider.
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.
274A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
274B	Authorized treatment plan has been altered; therefore, payment is disallowed.
274C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
274D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
278	Preventive control programs are included in the global fee.
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
280	Not payable when condition is asymptomatic.
281	Services solely for esthetic purposes are not benefits.
282	By-report procedure documentation missing or insufficient for payment calculations.
283	Payment amount determined from documentation submitted for this by-report procedure.
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.
284A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
284B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.

ARC #	Adjudication Reason Code Description
284C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
284D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
284E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.
285	Procedure does not show evidence of a reasonable period of longevity.
285A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
286	Procedure previously rendered.
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
287A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.
288	Procedure cannot be considered an emergency.
289	Procedure requires prior authorization.
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
291	Per date of service, procedure was completed prior to date of authorization.
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.
293A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
293C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.
294A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.

ARC #	Adjudication Reason Code Description
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
297	Procedure 803 not covered as a separate item. Global fee where a benefit.
298	A fee for completion of forms is not a covered benefit.
299	Complete denture procedures have been rendered/authorized for the same arch.
299A	Extraction procedure has been rendered/authorized for the same tooth.
300	Procedure recently authorized to your office.
300A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.
303A	Fixed Partial Dentures are not a benefit when the number of missing teeth in the posterior quadrant(s) do not significantly impact the patient's masticatory ability.
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.
305	Procedure not a benefit for tooth/arch/quad indicated.
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.
307A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.
307B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.
308	Procedure disallowed due to a beneficiary identification conflict.
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.
Payment Policy	
312	Certified orthodontist not associated to this service office.
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.

ARC #	Adjudication Reason Code Description
313A	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No other coverage EOB/RA, fee schedule or proof of denial submitted.
313B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
313C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
313D	Study models submitted are non-diagnostic, untrimmed, or broken.
313E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.
314A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
314B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
314C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.
314D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
314E	Per radiographs or documentation, please re-evaluate for: Procedure 706
314F	Per radiographs or documentation, please re-evaluate for: Procedure 708
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.
316	Payment disallowed. Request received over 12 months from end of month service was performed.
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).
317A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
317B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).
318	Recipient eligibility not established for dates of services.
318A	Recipient eligibility not established for dates of services. Share of cost unmet.
319	Rendering or billing provider NPI/ID not on file.
319A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.
320	Rendering or billing provider not enrolled for date of service.
320A	Rendering or billing provider is not enrolled as a certified orthodontist.

ARC #	Adjudication Reason Code Description
320B	The billing provider has discontinued practicing at this office location for these Dates of Service.
320C	Rendering provider has not submitted a proper attestation package.
321	Recipient benefits do not include dental services.
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.
326	Procedures being denied on this document due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document.
326A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.
327	Payment cannot be made; our records indicate patient deceased.
328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.
330A	Beneficiary is not eligible for Medi-Cal dental benefits. Verify beneficiary's enrollment in Healthy Families which may include dental benefits.
331	Authorized services are not a benefit if patient becomes ineligible during authorized period and services are performed after the patient has reached age 18 without continuing eligibility.
332	Share of cost patient must pay for these services.
333	Payment cannot be made for procedures with dates of service after receipt date.
333A	Payment disallowed. Date of service is after receipt date of first NOA page(s).
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.
335	Billing provider name does not match our files; payment/ authorization cannot be made.
336	Beneficiary is not eligible for dental benefits.
337	The procedure is not a benefit for the age of the beneficiary.

ARC #	Adjudication Reason Code Description
337A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.
338	This service will be processed under the former contract separately.
339	The POE label on the claim appears to be altered. Please contact the recipient's county welfare office to validate eligibility. Resubmit the claim with a valid label.
340	This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a Claim Inquiry Form (CIF). The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim.
341	This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a Claim Inquiry Form (CIF). This denied, duplicate procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)
342	Rendering provider required for procedure, none submitted.
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
345	Payment cannot be made for procedures with invalid dates of service.
345A	The PM 160 form sent was not current. Send claim inquiry form with current PM 160 form or document reason for delay in treatment.
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.
347	Authorization previously denied, payment cannot be made.
348	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service already performed on the same day by the same DDS.
348A	The billed procedure cannot be paid because there is an apparent discrepancy between it and procedure D0220 already performed on the same day. If you are requesting re-adjudication for this procedure, submit a Claim Inquiry Form (CIF).
349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.
350	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided for this patient.
351	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided by your office for this patient.
352	The billed service is disallowed because of an apparent discrepancy with a related procedure billed by your office for the same tooth on the same day.

ARC #	Adjudication Reason Code Description
352a	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
353	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
354	The line item is a duplicate of a previous line item on the same claim.
355A	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355B	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355C	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
356	EOMB for different recipient, procedure(s) denied.
357	Procedure deleted/disallowed per provider request.
358	Payment for procedure disallowed per claims review.
359	Payment for procedure disallowed per clinical post-payment review.
360	Sign Notice of Authorization for payment of dated lines.
361	CSL has not been paid; NOA never returned for payment.
362	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
363	Procedure on EOMB is not a benefit of the program.
364	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
365	The maximum allowance for this service/procedure has been paid by Medicare.
366	Dental benefits cannot be paid without proof of payment/denial from Medicare.
367	Medicare payment/denial notice does not have recipient name and/or date of service.
368	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
369	Emergency certification statement is insufficient /not submitted for recipient aid code.
369A	Provider must sign the emergency certification statement.
370	Procedure not a benefit for recipient aid code.
370A	Per box “D” marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
371	Procedure(s) cannot be prior authorized for recipient aid code.
372	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
373	Procedure not payable. CTP benefits terminate at age 19.

ARC #	Adjudication Reason Code Description
374	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.
376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.
377	This procedure is not a benefit for an RDHAP/RDHEF/RDH.
377A	Procedure requested is only payable when the patient resides in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF) that is licensed pursuant to Health And Safety Code (H&S Code) Section 1250-1264.
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
380	Fee adjustment, since Other Coverage exists for this claim.
381	Fee adjustment, since Third Party Liability exists for this claim.
382	Fee adjustment, since share of cost exists for this claim.
383	Fee adjustment, since services billed were not provided.
384	Fee adjustment, due to findings of professional peer review.
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).
386A	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).
387A	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
392	Beneficiary is not eligible for CCS/GHPP benefits.

ARC #	Adjudication Reason Code Description
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.
400	EPSDT services are not a benefit for patients 21 years and older.
401	The EPSDT service requested is primarily cosmetic in nature and not medically necessary per EPSDT criteria.
402	An alternative service is more cost effective than the requested EPSDT service and is a benefit of the Medi-Cal dental program. Please re-evaluate.
403	The EPSDT service requested is not medically necessary.
403A	Procedure has been allowed under EPSDT criteria.
403B	Procedure code was allowed under EPSDT criteria. In addition, procedure code also qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook Section 4 - Treating Members.
403C	The requested procedure could be considered with EPSDT documentation; however, none was submitted.
404	Procedure is disallowed due to presumptive eligibility card not submitted.
405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.
437	CRA procedure code must be performed in a DTI domain 2 county.
437A	CRA procedure code must have the same dates of service and be billed on the same claim.
438A	CRA procedure code is allowable once every 6 months for low risk patients.
438B	Procedure D1354 is allowable once every 6 months when CRA includes high risk procedure D0603.
438C	CRA procedure code is allowable once every 4 months for moderate risk patients.
438D	CRA procedure code is allowable once every 3 months for high risk patients.
438E	Additional services are allowable in conjunction with CRA procedure codes.
439	Payment denied due to lack of DTI domain 2 Funding.
440	Procedure Code D1354 is allowable two visits per year, and lifetime maximum of four times per tooth.
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.
501	Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.

ARC #	Adjudication Reason Code Description
503A	Optional Adult Dental procedure is not a benefit
503B	Optional Adult Dental procedure is not a benefit
505	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 - Treating Members.
505A	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 – Treating Members. Additional services are allowable in conjunction with CRA procedure codes.
506	Procedure Code qualifies for CalAIM Preventive Services Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.
507	Procedure Code qualifies for CalAIM Continuity of Care Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.
555B	Authorization of this line is no longer valid: Treatment was performed as an emergency.
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed.
777	A special exception has been made for this procedure based on the documentation submitted.
888	Line allowed but unpaid due to date of service
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.
Clinical Screening Codes	
603	Per clinical examination, procedure requested is only allowable under special circumstances.
607A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.
607B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
613A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.
613B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.

ARC #	Adjudication Reason Code Description
614A	Per clinical screening, please re-evaluate for: Complete upper denture
614B	Per clinical screening, please re-evaluate for: Complete lower denture
614C	Per clinical screening, please re-evaluate for: Resin base partial denture
614D	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
614E	Per clinical examination, please re-evaluate for: Procedure 706.
614F	Per clinical examination, please re-evaluate for: Procedure 708.
619	Per clinical screening, caries not clinically verified.
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
648	Per clinical screening, extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
649A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
662	Per clinical screening, existing prosthesis is adequate at this time.
662A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.

ARC #	Adjudication Reason Code Description
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
666A	Per clinical screening, the patient's medical condition does not preclude the taking of radiographs.
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
667A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.
668	Per clinical screening, the need for procedure is not medically necessary.
668A	Per clinical screening, patient does not wish extractions or any other dental services at this time.
668B	Per clinical screening, patient has selected/wishes to select a different provider.
669A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.
669B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
669C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.
671A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
671B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
671C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
671D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
671E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.
671F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
671G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.

ARC #	Adjudication Reason Code Description
671H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
671I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.
672	Per clinical screening, tooth not present.
672B	Per clinical screening and/or radiographs, tooth number may be incorrect.
673A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
674	Per clinical screening, incomplete treatment plan submitted.
674A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
674C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
680	Per clinical screening, services solely for esthetic purposes are not benefits.
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.
684A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.
684B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.
684C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.
684D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
684E	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Two or more of the above pertain to your case.
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.
685A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
687	Per clinical screening, allowance made for alternate procedure.
692	Per clinical screening, documentation or radiographs, procedure already completed.

ARC #	Adjudication Reason Code Description
693	Per clinical screening, procedure requested is inadequate to correct problem.
693A	Per clinical screening, procedure requested is inadequate to correct problem. Tooth has open, underformed apices. Authorization for root canal will be considered after radiographic evidence of apex closure following apexification.
693B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.
693C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.
694A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.
695	Authorization disallowed as the patient is no longer at the facility.
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.