



## Denti-Cal Provider Guide

This is a summary of key information and requirements of the Denti-Cal program. It is not meant to replace the detailed information in the *Medi-Cal Dental Program Provider Handbook (Provider Handbook)*. Dentists should familiarize themselves with the contents of the *Provider Handbook* and visit the Denti-Cal program [website](#) frequently.

Additionally, dentists should sign up for the [Denti-Cal Fee for Service Provider email distribution list](#) to receive important news and updates regarding the Denti-Cal program.

### I. Processing a Denti-Cal Patient Through the Dental Practice

#### **First and foremost, treating and billing dentists must be enrolled as Denti-Cal providers:**

- The first criterion for treating Denti-Cal patients is to assure that every dentist in the office providing care to Denti-Cal patients is enrolled as a Denti-Cal provider.
- Enrollment applies to both “billing providers” (i.e., the practice owner) and “rendering providers” (i.e., any associate treating Denti-Cal patients).
- **Only Denti-Cal-enrolled dentists should treat Denti-Cal patients. Non-enrolled providers will not be paid for treatment provided to Denti-Cal patients and could be subject to civil penalties in addition to licensure action.** Visit the Denti-Cal [website](#) to view provider enrollment requirements in the *Medi-Cal Dental Program Provider Handbook (Provider Handbook)* and the [Enrollment Tool Kit](#) under the Providers tab.

#### **Verifying patient eligibility:**

- Make a copy of the patient’s Medi-Cal beneficiary identification card (BIC).
- Verify and copy patient’s photo identification. Copy the parent’s identification if the patient is a minor.
- Patient eligibility should be verified one time each month that services are provided. Provider should retain a copy of eligibility with the patient’s record. Eligibility may be verified electronically over the internet at [medi-cal.ca.gov/Eligibility/Login.asp](http://medi-cal.ca.gov/Eligibility/Login.asp) or through a Point of Service device. See [Section 4](#), “Treating Beneficiaries,” of the *Provider Handbook*, or call the POS/Internet Help Desk at **800.427.1295**. All inquiries about PIN, billing, claims, Point of Service devices and Automated Eligibility Verification System number issues should be directed to the Medi-Cal Telephone Service Center at **800.541.5555**.
- See [Section 4](#), “Treating Beneficiaries,” of the *Provider Handbook* for more information on verifying patient eligibility.

#### **Important information for providers:**

Dental offices may acquire a variety of information about the patient’s history, the status of a claim and their provider enrollment status by calling **800.423.0507** and following the prompts to access specific information.

**Covered benefits:**

- Based on the aid code, patients up to age 21 enrolled as Medi-Cal beneficiaries are eligible for Denti-Cal.
- All covered Denti-Cal benefits, with diagnostic policies and documentation requirements, are located in [Section 5, "Manual of Criteria and Schedule of Maximum Allowances,"](#) of the *Provider Handbook*.
- Common procedures — examinations, prophylaxis, amalgam and composite fillings, stainless steel crowns, pulpotomies, space maintainers, dental sealants and all emergency procedures — may not require prior authorization. See [Section 5](#) of the *Provider Handbook* for specific procedures requiring prior authorization.
- Note policies on covered orthodontic procedures in [Section 5](#) of the *Provider Handbook*, on [page 5-103](#), and orthodontic procedures requiring prior authorization in [Section 2, "Program Overview,"](#) on [page 2-19](#), of the *Provider Handbook*.
- Prior authorization is needed for root canal therapy and cast crowns and is recommended for extraction of third molars. (See [Section 6, "Forms,"](#) [page 6-6](#) of the *Provider Handbook*, for requesting preauthorization).
- For further clarification on Denti-Cal's policy on third molar extraction, see the [January 2011 Denti-Cal Bulletin](#).

**Adults older than 21 are eligible for:**

- Certain services identified as "Federally Required Adult Dental Services (FRADS)" (see [Section 4, "Treating Beneficiaries,"](#) [page 4-8](#) of the *Provider Handbook*); Effective May 1, 2014, certain services identified as "Restored Adult Dental Services (RADS)" (see [Section 4, "Treating Beneficiaries,"](#) [Page 4-8](#) of the *Provider Handbook*).
- Restored procedures include the following: initial examinations, radiographs/photographic images, prophylaxis, fluoride treatments, amalgam and composite restorations, prefabricated crowns (stainless steel, resin and resin window), anterior root canal therapy, complete dentures (including immediate dentures), and complete denture adjustments, repairs and relines.
- See [2014 Denti-Cal Bulletin, volume 30, number 9](#).
- Dental services necessary as a condition for other covered medical treatment (see [2009 Denti-Cal Bulletin, volume 25, number 22](#)).
- Pregnant and postpartum women are eligible for certain dental benefits (see [Section 4, "Treating Beneficiaries,"](#) [page 4-10](#) of the *Provider Handbook*).
- Adult patients in long-term care (LTC), or skilled nursing facilities (SNF), and intermediate care facilities (ICF), are eligible for certain Denti-Cal benefits (see [Section 4, "Treating Beneficiaries,"](#) [page 4-11](#) of the *Provider Handbook*).
- Regional Center consumers (State Department of Developmental Disabilities beneficiaries), as well as special needs patients, are eligible for full-scope dental services through Medi-Cal. See [November 2011, Denti-Cal Bulletin volume 27, number 13](#).
- For details, contact the Denti-Cal Service Center at **800.423.0507**.

**II. Denti-Cal Billing Process****Use of the TAR/claim form:**

The Treatment Authorization Request (TAR)/claim form is a single form used to request **preauthorization** of treatment from Denti-Cal and **to file claims** for reimbursement for services.

- The submitted (TAR)/claim should reflect your clinical findings at the time of diagnosis.
- Take necessary radiographs and photographs when making a diagnosis so Denti-Cal can see your clinical findings when making the diagnosis.

- Radiographs are required for many procedures to show medical necessity of treatment. See [page 2-17](#) of the *Provider Handbook*.
- Photographs or radiographs submitted to Denti-Cal will not be returned to you.
- Intraoral photographs of teeth are needed on all occlusal, buccal or lingual tooth surfaces to document caries not seen on radiographs or for any other clinical situations you may need to demonstrate.
- Radiographs are required to justify medical necessity when pre-authorizing scaling and root planing, crowns and root canal therapy.
- All periodontal procedures require submission of radiographs.
- Retain all radiographs, photos and notes for your records and only send copies of these to Denti-Cal.
- See [Section 5](#), "Schedule of Maximum Allowances," of the *Provider Handbook* for photographic and radiographic document requirements for specific planned procedures.
- Note [Section 2](#), "Program Overview," [pages 2-19](#) and [2-20](#) in the *Provider Handbook* for a list of procedures requiring preauthorization.
- See [Section 6](#), "Forms," [page 6-6](#) of the *Provider Handbook* for information on the TAR/claim form.
- See [Section 6](#), "Forms," [page 6-35](#) of the *Provider Handbook* for a checklist of information that should be provided on the claim form.

### **Submitted claim form:**

Denti-Cal will respond to a submitted claim in one of two ways:

It will either pay — or deny payment — for the service and communicate that to the dentist through the Explanation of Benefits (EOB) form.

**or**

It will issue a "Resubmission Turnaround Document" (RTD) form requesting additional information necessary to process the claim.

### **Explanation of Benefits (EOB):**

- Provides details for which procedures were paid and those procedures that were denied on a submitted claim.
- EOBs are issued as part of a bulk payment each week and lists claims that have been in process for more than 18 days.
- See [Section 6](#), "Forms," [page 6-45](#) to [page 6-47](#) of the *Provider Handbook* for more information on the EOB.

### **Resubmission Turnaround Document (RTD):**

- Itemizes the additional information that Denti-Cal needs to process a submitted claim or request for preauthorization.
- The dentist has 45 days from the date the RTD issue date to provide the requested information to Denti-Cal.
- See [Section 6](#), "Forms," [page 6-25](#) of the *Provider Handbook* for information on the RTD.

### **Avoiding authorization and claim denials:**

On both TARs and claims:

- Assure that radiographs, if required, are of diagnostic quality and show what you are seeing as needing treatment.
- Assure that photographs are being submitted to support the procedure being claimed.

- Assure that radiographs and photographs are properly labeled per the Diagnostic General Policies of the *Provider Handbook* located in [Section 5](#) on pages [5-5](#) and [5-6](#).
- Consider whether radiographs submitted for payment of restorations demonstrate the restoration was medically necessary.
- Attach treatment notes or other written documentation to show medical necessity of procedures claimed.
- Check the claim form to assure all required information has been entered and that the form is signed by the dentist. **Denti-Cal forms must be signed in blue or black ink.**

**Common reasons for claim denials:**

- Incomplete or nonsubmission of necessary radiographs, photographs or written documentation.
- Claims and documentation that fail to show that treatment was medically necessary.
- Radiographs and photographs not properly labeled or of nondiagnostic quality.
- Clerical errors such as failure to enter dates of service, failure to include treating dentist's NPI or failure to sign claim form.

**Using a Notice of Authorization (NOA) form for preauthorized treatment:**

- TARs submitted for prior authorization of treatment will generate a Notice of Authorization form for preauthorized procedures.
- Completed NOA is required to be submitted to Denti-Cal when treatment is completed.
- See [Section 6](#), "Forms," [page 6-15](#) to [page 6-19](#) of the *Provider Handbook* for more information on the NOA.

**If a claim is denied:**

- When a claim or request for preauthorization is denied, check the adjudication reason code for the denial, found in [Section 7](#), "Codes," beginning on [page 7-1](#) of the *Provider Handbook*. When an entire document is denied, refer to the TAR/Claim Policy Codes and Messages, found in [Section 7](#), "Codes," beginning on [page 7-29](#) in the *Provider Handbook*.
- Denials referenced on an EOB may be resubmitted using a Claim Inquiry Form (CIF – see [Section 6](#) on [page 6-29](#) of the *Provider Handbook*).
- If in response to a CIF, Denti-Cal upholds the original denial, a provider may request a formal "First Level Appeal." (See [Section 2](#), "Program Overview," [page 2-11](#) of the *Provider Handbook* on both the CIF process and first-level appeals.)

**Denti-Cal provides direct assistance to dentists:**

If you need live assistance on anything related to claim documentation, patient eligibility or covered benefits, call the Denti-Cal Provider Telephone Service Center at **800.423.0507**.