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Denti-Cal
California Medi-Cal Dental

Bulletin

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This Issue:

Training Seminars

Reserve an available spot for one of our open training seminars.

Ontario
Basic & EDI/D586– Nov. 4, 2015
Advanced/D587 - Nov. 5, 2015

Webinar
Workshop/D588 - Nov. 10, 2015

Orange
Basic & EDI/D589 - Nov. 18, 2015
Advanced/D590 - Nov. 19, 2015

Provider Enrollment Assistance Line

Speak with an Enrollment Specialist. Go here for more information!

Wednesday, Nov. 18, 8 am - 4 pm.

Effective December 1, 2015 Rendering Provider National Provider Identifier (NPI) Number Required on All Dated Procedures Submitted For Payment

Effective December 1, 2015, a rendering provider NPI number will be required for all procedure codes on all dated claim service lines on Claims, Notices of Authorization (NOAs), and adjustments. Rendering provider NPI information will be required as a prerequisite to payment of all services.

All procedure codes listed on a claim, NOA, or adjustment document shall require the rendering provider NPI number regardless of the status of the billing provider (i.e. a group or individual practice). If field 33 is blank on any dated service line, a Resubmission Turnaround Document (RTD) will be issued to the provider to request the rendering provider NPI number of the provider that performed the procedure. If a rendering provider NPI number is not submitted in response to the RTD, the procedure on that service line will be denied.

For questions regarding this, please call the Denti-Cal Provider Customer Service line at 800-423-0507.

Billing Providers Must Ensure Their Rendering Providers Are Enrolled

Billing providers MUST ensure that all their rendering providers are enrolled in the Denti-Cal Program prior to treating Medi-Cal beneficiaries. To receive payment for dental services rendered to Medi-Cal beneficiaries, prospective providers must apply and be approved by Denti-Cal to participate in the Denti-Cal Program. Payments made to billing providers for services performed by their rendering providers who are not enrolled in the Denti-Cal Program may be subject to payment recovery. Title 22 Section 51458.1(a)(6) states:

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(a) The Department shall recover overpayments to providers including, but not limited to, payments determined to be:

(6) For services prescribed, ordered or rendered by persons who did not meet the standards for participation in the Medi-Cal program at the time the services were prescribed, ordered or rendered.

Rendering providers are required to submit a complete DHCS 6216 (rev.2/08) Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers. Instructions about enrolling in the Denti-Cal Program are found in the Provider Handbook, Section 3: Enrollment Requirements.

For more information, contact the Denti-Cal Provider Customer Service line at 1-800-423-0507; view our Provider Enrollment Tool Kit; or register for the monthly Provider Enrollment Assistance Line to be held on Wednesday, November 18, 2015.

Submit a Properly Completed Justification of Need for Prosthesis (DC054) Form with Requests for Prosthetics

Ordering the DC054 Form

Providers can order Justification of Need for Prosthesis forms (DC054) by filling out the Forms Reorder Request found electronically on the Denti-Cal website or the hard copy form included in each Denti-Cal inventory order. The completed order form can either be faxed to (877) 401-7534 or mailed to this address:

Denti-Cal Forms Reorder
11155 International Dr.
MS C210
Rancho Cordova, CA 95670

Using the DC054 Form

Providers are required to submit a DC054 form when submitting a Treatment Authorization Request (TAR) for all prosthetic appliances (except full immediate dentures). The DC054 provides complete and detailed information necessary for screening and processing prosthetic cases. The form should include specific information describing the beneficiary's oral condition and the condition of any existing prosthetic appliances.

Failure to submit a DC054 form will cause a delay processing the request. If the information on the DC054 form is incomplete or contradictory, the requested prosthetic appliance(s) will be denied with Adjudication Code 155 (Procedure requires a properly completed prosthetic DC054 form).

NEED MORE INFORMATION?

Provider Enrollment Workshops

Are you a dental provider who is interested in joining the Denti-Cal program but don't know where to start? Do you have questions about the Denti-Cal enrollment process? Then please drop-in anytime during the hours scheduled below to attend one of our enrollment workshops! Registration is preferred, but not required.

Date/Time:	Location:	County:
Friday, Nov. 6, 2015 8:00 AM- 4:00 PM Register Now!	Embassy Suites 8425 Firestone Blvd Downey, CA 90241	Los Angeles County
Friday, Nov. 20 2015 8:00 AM- 4:00 PM Register Now!	Embassy Suites Anaheim - Orange 400 N. State College Boulevard Anaheim, CA 92868	Orange County

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If enrolled to submit electronically, providers also have the option to submit the DC054 form as an electronic attachment with a TAR.

Providers are required to use the current version of the form, which is **(R10/05).**

How to Complete the DC054 Form

The following is a sample DC054 form with instructions on how to correctly complete the document.

1. **PATIENT NAME**: Enter the beneficiary's name exactly as it appears on the Medi-Cal Beneficiary Identification Card (BIC).
2. **DATE**: Enter the date the beneficiary was evaluated.
3. **APPLIANCE REQUESTED**: Enter the type of prosthetic appliance requested on the TAR.
4. **EXISTING APPLIANCE**: Enter the type of prosthetic appliance that the beneficiary has or had (regardless of the condition of the appliance or whether the appliance has been lost, stolen, or discarded). If the beneficiary has never had any type of prosthetic appliance, check the corresponding box.

   Indicate whether the beneficiary wears the existing appliance and the age of the appliance that the beneficiary has (or had). If the appliance is no longer present due to a catastrophic loss (fire, earthquake, theft, etc.), attach the Official Public Service Agency Report. If the prosthetic appliance has been lost in a certified facility or hospital, document the date of the incident and the circumstances of the loss. If needed, use the "Additional Comments" section on the DC054 form for documenting details of the loss.
5. **EVALUATION OF EXISTING PROSTHETIC APPLIANCES AND/OR EXISTING ORAL CONDITIONS**: Document the condition of the existing denture base, denture teeth, retention, opposing natural dentition (if applicable), centric occlusion, and vertical relation. If the existing appliance is a cast metal framework partial denture, document the condition of the framework.

   When checking a box indicating "inadequate," a brief explanation is required documenting the reason for the inadequacy.

   When requesting a prosthetic appliance for only one arch, the opposing arch must also be addressed.

   The condition of the soft tissue and hard tissue must be evaluated and reported as either adequate or inadequate — even when the beneficiary does not have an existing prosthetic appliance. If soft tissue or hard tissue is checked "inadequate," indicate the procedure that will be necessary to correct the inadequacy prior to the construction of an appliance, e.g., tissue conditioning, tuberosity reduction, excision of hyperplastic tissue, removal of tori, etc.

   Note: If required documentation is not included, the requested services will be denied.
6. **MISSING TEETH**: Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
7. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL**: Indicate the teeth being replaced by the requested appliance and the teeth being clasped.
8. **NATURAL TEETH BEING RETAINED**: If teeth are being retained in the arch(es), indicate the treatment plan for the remaining teeth (root canals, periodontal treatment, restorative, crowns, etc.).
9. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the beneficiary, indicate whether the beneficiary wants the proposed services.
10. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the beneficiary to wear a prosthetic appliance. Document if the condition is temporary or permanent.
11. **ADDITIONAL COMMENTS**: Use this section for additional comments/documentation specific to the requested treatment.
12. **CONVALESCENT CARE**: If the beneficiary resides in a convalescent facility, document facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment. The TAR should include the facility name, address, and phone number.
13. **SIGNATURE AND LICENSE NUMBER**: The form must be completed by the dentist who evaluated the patient. The dentist must sign the form and enter his/her dental license number.

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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. Both arches must be evaluated and addressed. Chart missing teeth and teeth to be extracted. Complete each section of the form. Attach this form to the submitted TAR.

(1) **PATIENT:** _____ (2) **DATE:** _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE ITEM *(TYPE OR PRINT CLEARLY)*

MAXILLARY ARCH	**MANDIBULAR ARCH**
(3) Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
(4) Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Existing Appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Never had a maxillary prosthetic appliance	☐ Never had a mandibular prosthetic appliance
Wears appliance? ☐ Yes ☐ No Age of Appliance: _____	Wears appliance? ☐ Yes ☐ No Age of Appliance: _____
Catastrophic Loss? ☐ Yes ☐ No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.	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: _____	If lost in facility or hospital, explain circumstances: _____

(5)

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	☐	☐		☐	☐	
Framework	☐	☐		☐	☐	
Denture Teeth	☐	☐		☐	☐	
Retention	☐	☐		☐	☐	
Soft Tissue	☐	☐		☐	☐	
Hard Tissue	☐	☐		☐	☐	
Opposing Dentition	☐	☐		☐	☐	
Centric Occlusion	☐	☐				
Vertical Relation	☐	☐	Open ___ mm. Closed ___ mm			

(6) ☐ Edentulous ☐ Maxillary ☐ Mandibular

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

X Block out missing teeth ○ **Circle teeth to be extracted**

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH	**MANDIBULAR ARCH**
(7) Teeth Being Replaced: _____	Teeth Being Replaced: _____
Teeth Being Clasped: _____	Teeth Being Clasped: _____

(8) If treatment involves retaining teeth in the arch(es), indicate treatment plan for remaining teeth (Root canals, periodontal treatment, restorative, crowns, etc.): _____

(9) Does the patient want requested services? ☐ No ☐ Yes

(10) Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes Explain: _____

(11) **ADDITIONAL COMMENTS:** _____

(12) **CONVALESCENT CARE:** Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver: _____

(13) Provider Signature _____ License # _____

DC 054 (R10/05)

If you have any questions, please contact the Provider Customer Service line at 1-800-423-0507.

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Effective December 1, 2015, Denti-Cal will No Longer Return Radiographs or Photographs to Providers

Beginning December 1, 2015, Denti-Cal will no longer be returning printed diagnostic documentation (e.g., radiographs or photographs) to providers, regardless of whether providers request to have their documentation returned or when the documentation was received. Providers are reminded that, according to the accepted standard of dental practice and the Medi-Cal Dental Provider Handbook, the fewest number of radiographs needed to provide a diagnosis shall be taken. Providers are also reminded that only copies of radiographs are to be submitted because original radiographs must be a part of the patient's clinical record and must be retained by the provider at all times. Providers are advised that patient records may be subject to audits and that it is the responsibility of the provider to maintain the patient record. Additional information regarding diagnostic documentation can be found in "Section 2 – Program Overview" in the Provider Handbook.

Digitized radiographs and other documentation may be submitted in conjunction with claims and Treatment Authorization Requests submitted electronically. If you wish to submit documents electronically, providers must apply and be approved to participate in the Electronic Data Interchange (EDI) program. For information on EDI enrollment, please contact the Denti-Cal Provider Customer Service line at (800) 423-0507 or EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org).

Digitized Images and Electronic Data Interchange (EDI) Documents

When submitted electronically with claims and Treatment Authorization Requests (TARs), Denti-Cal accepts digitized images submitted through the following electronic attachment vendors: National Electronic Attachment, Inc. (NEA), National Information Services (NIS), and Tesia Clearinghouse, LLC.

In order to submit digitized images, providers must apply and be approved to participate in the Electronic Data Interchange (EDI) program. For more information on EDI enrollment, please contact the Denti-Cal Provider Customer Service Line at (800) 423-0507 or EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org).

Electronic Vendor and Document Specifications

The following documentation related to EDI claims and TARs can be submitted electronically through NEA, NIS, or Tesia Clearinghouse, LLC web sites:.

Images That CAN Be Transmitted:	Images That CANNOT Be Transmitted:

• Documentation related to claims and TARS to be submitted electronically:
  • Radiographs
  • Justification of Need for Prosthesis Forms (DC054)
  • Photos
  • Narrative documentation (surgical reports, etc.)
	• Any documentation related to claims and TARs submitted on paper.
	• Claim Inquiry Forms (CIFs), Resubmission Turnaround Documents (RTDs), or Notices of Authorization (NOAs) issued for paper or EDI documents

- **NEA Users**: Radiographs/photographs and attachments must be transmitted to NEA before submitting an EDI claim or TAR. NEA's reference number must be entered on the EDI claim or TAR using the following format: "NEA#" followed by the reference number, with no spaces. For example:

  NEA#9999999

  It is important to use this format and sequence. Some dental practice management and electronic claims clearinghouse software have an interface with NEA that automatically enters the reference number into the notes of the claim.

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Questions related to this instruction may be directed to NEA at (800) 782-5150 option 3. For NEA enrollment information, visit http://www.nea-fast.com and enter promotion code DCALRZ1M (expires 1/1/2016).

- **NIS Users**: Create your claim or TAR. Before transmitting a document electronically, attach your radiographs/photographs and attachments. Use your Document Center to scan images, photos, etc.

  For NIS information, call (800) 734-5561 and select option #1.

- **Tesia Clearinghouse, LLC**: Create your claim or TAR. Before transmitting a document electronically, include your radiographs/photographs and attachment.

  For Tesia Clearinghouse, LLC information, call (800) 724-7240.

Images should not be transmitted electronically for EDI claims or TARs that have already been submitted and are waiting for radiographs and/or attachments to be mailed. Digitized images of CIFs, RTDs, and NOAs cannot be processed electronically.

Image Dates

All radiograph/photograph images submitted electronically require an "image created date" that references the date the radiographs/photographs were taken in the office.

Image Reference Numbers for CIFs Related to EDI and Paper Documents

Providers have the option of not submitting hard copies of radiographs and other documentation related to a CIF if the provider indicates digitized image reference numbers in the form's remarks box. If a provider chooses not to include digitized image reference numbers on a CIF, then the provider must send in hard copies.

For additional information on how to submit reference numbers, also referred to as attachment control numbers, refer to the HIPAA Transaction Standard Companion Guide [Denti-Cal EDI (Electronic Data Interchange) Companion Guide].

Please note that tips to successfully using EDI can be found as attachments to this bulletin. For more information on sending digitized images to Denti-Cal, contact EDI Support at (916) 853-7373.

Sign-Up for the Denti-Cal Fee-For-Service Provider E-Mail List

The Denti-Cal Provider E-Mail List is another option to receive updates related to the Denti-Cal program. To subscribe to the Denti-Cal Provider E-Mail List, please visit http://www.denti-cal.ca.gov/WSI/Prov.jsp?fname=dc_provider_email_signup_form and complete the online form. After submitting the form, an e-mail will be sent requesting authorization to be added to the e-mail list. After approval has been made, providers will receive regular updates and information about the Denti-Cal program. Providers may unsubscribe from the e-mail list at any time.

Questions related to this topic or the Denti-Cal program in general can be directed to the Provider Customer Service line at 1-800-423-0507.