

SHD Paraphrased Regulations - Medi-Cal

530 Scope of Benefits - General and Dental

530-1

State law and regulations provide that when prior authorization is required, the Director shall require fully documented medical justification from providers that requested services are medically reasonable and necessary to prevent significant illness, to alleviate severe pain, to protect life or to prevent significant disability. (Welfare and Institutions Code §14133.3; §51303)

530-2

Retroactive approval of requests for prior authorization may be granted when a patient does not identify himself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of a physical or mental incapacity to so identify himself. The request for retroactive authorization shall be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month in which the service was rendered. The request for retroactive authorization shall be submitted within 60 days of the certified date of beneficiary identification. (§51003(b)(4))

530-3 REVISED 12/08

"Prior authorization," or "authorization" means authorization granted by a designated Medi-Cal consultant or by a Primary Care Case Management (PCCM) plan and is obtained through submission and approval of a TAR.

(§51003(a))

530-3A ADDED 12/08

"Reauthorization" means authorization of a new TAR for continuation of previously authorized Medi-Cal services. (§51003(c))

530-3B ADDED 12/08

In addition to indicating the beneficiary identification, provider information, diagnosis and other pertinent information, and the service or item required, the provider submitting a TAR shall explain why the services are medically necessary or submit supporting documentation indicating medical necessity.

A TAR received by the Department from a Fee-For-Service Medi-Cal provider shall be reviewed for medical necessity only.

(§§51003(b) and (d))

530-4 REVISED 3/06

Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi-Cal Authorization" published by the Department in January 1982, and last revised on January 1, 2006, and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi-Cal Consultants or PCCM plans in their decisions on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified by the consultant up to a maximum of 180 days, unless otherwise specified. The Medi-Cal consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years. (§51003(e))

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Authorization may be granted only for the lowest cost item or service covered by the Medi-Cal program that meets the beneficiary's medical needs. (§51003(f))

530-6

Experimental services are not covered under the Medi-Cal Program. (§51303(g))

530-7

Medi-Cal beneficiaries who are eligible for benefits under that program and for the same full or partial benefits under any other State or Federal medical care program or under other contractual or legal entitlements must use those other benefits before using Medi-Cal covered benefits. The requirement does not apply to beneficiaries under Medi-Cal capitated contracting arrangements unless the requirement is contained in the contract. (§51005(a))

530-8

When a proposed treatment meets objective criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of five working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of five working days. (Welfare and Institutions Code (W&IC) §14133.9)

531-1

Full dentures, removable partial dentures that are necessary for the balance of a complete artificial denture, stayplates and reconstructions of removable dentures using standard procedures which exclude precision attachments or implants are covered benefits under the Medi-Cal Program subject to prior authorization. These services are covered only once in a five-year period by the Medi-Cal Program except when necessary to prevent a significant disability or to replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control. (§51307(e)(7))

531-1A REVISED 6/08

Prior authorization is required for removable prostheses. Precision attachments, implants or other specialized techniques are not a benefit.

Prior authorization shall be considered for a new (i.e., replacement) prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or relines.

(Denti-Cal Manual Of Criteria-Prosthodontics (Removable) General Policies, Section 5 effective March 1, 2008)

531-1B REVISED 6/08

New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist

The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.

(Denti-Cal Manual of Criteria- Prosthodontics (Removable) General Policies, Section 5 effective March 1, 2008)

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531-1C REVISÉD 6/08

A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:

- i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or
- ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or
- iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

(Denti-Cal Manual of Criteria- Prosthodontics (Removable) General Policies, Section 5 effective March 1, 2008)

531-1D REVISÉD 6/08

The following prosthodontic services are not covered benefits:

Prosthodontic services provided solely for cosmetic purposes.

Temporary or interim dentures to be used while a permanent denture is being constructed.

Spare or backup dentures.

Partial dentures to replace missing 3rd molars.

Immediate dentures shall be considered when one or more of the following conditions exist:

- i) extensive or rampant caries are exhibited in the radiographs,
- ii) severe periodontal involvement is indicated in the radiographs,
- iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.

(Denti-Cal Manual of Criteria- Prosthodontics (Removable) General Policies, Section 5 effective March 1, 2008)

531-1E ADDED 6/08

PROCEDURE D5211 and 5212

MAXILLARY AND MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

Prior authorization is required.

A benefit once in a five-year period

A benefit when replacing a permanent anterior tooth/teeth and/or the

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arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:

- a. five posterior permanent teeth are missing, (excluding 3rd molars), or
- b. all four 1st and 2nd permanent molars are missing, or
- c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.

Not a benefit for replacing missing 3rd molars.

Note: Procedures D5211 and D5212 do not have to have an opposing full denture.

(Denti-Cal Manual of Criteria- Prosthodontics (Removable) Procedures, Section 5 effective March 1, 2008)

531-1F ADDED 6/08

PROCEDURES D5213 AND D5214

MAXILLARY AND MANDIBULAR PARTIAL DENTURE- CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

Prior authorization is required.

A benefit once in a five-year period.

A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:

- a. five posterior permanent teeth are missing, (excluding 3rd molars), or
- b. all four 1st and 2nd permanent molars are missing, or
- c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.

Not a benefit for replacing missing 3rd molars.

(Denti-Cal Manual of Criteria- Prosthodontics (Removable) Procedures, Section 5 effective March 1, 2008)

531-3

Laboratory processed crowns for permanent teeth are a covered benefit subject to prior authorization. (§51307(e)(6))

531-3A REVISED 6/08

The following sets forth Denti-Cal procedures in regard to laboratory processed crowns

GENERAL POLICIES - CROWNS

Prior authorization is required.

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A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:

- i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:
 - a. the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,
 - b. the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,
 - c. an incisal angle is not involved but more than 50% of the anatomical crown is involved.
- ii) Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp. Restorative General Policies (D2000-D2999)
- iii) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.
- iv) Posterior crowns for patients age 21 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests or for a fixed partial denture which meets current criteria.

Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

Arch integrity and overall condition of the mouth, including the patient'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 to be crowned.

(Denti-Cal Manual of Criteria Restorative General Policies-Laboratory Processed Crowns, Section 5)

531-3B REVISED 6/08

Laboratory processed crowns on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy and require prior authorization. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of laboratory processed crowns.

Cast or prefabricated posts are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

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(Denti-Cal Manual of Criteria Restorative General Policies-Laboratory Processed Crowns, Section 5)

531-3C ADDED 6/08

Treatment of dental caries with silver amalgam, silicate cement, acrylic, composite, plastic restorations or stainless steel crowns, except for incipient or nonactive caries in adults, is a covered benefit. (§51307(b)(8))

Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite. (Denti-Cal Manual of Criteria Restorative General Policies, Section 5, March 1, 2008)

531-5

Removable partial dental prostheses are not a covered benefit under the Medi-Cal Program except when necessary for balance of a complete artificial denture. (§51307(d)(4))

531-6 REVISED 6/08

The following sets forth Denti-Cal procedures in regard to periodontics:

Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.

Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist).

Documentation specifying the definitive periodontal diagnosis is required for prior authorization. Current periapical radiographs of the involved areas and arch radiographs are required for periodontal scaling and root planing and osseous surgery for prior authorizations. A panoramic film alone is non- diagnostic for periodontal procedures.

A current and complete periodontal evaluation chart is required with prior authorizations with the following criteria:

- i) periodontal evaluation charts are considered current when dated no more than 12 months before the request for prior authorization and when no subsequent periodontal treatment has been performed, and
- ii) at least four pocket depths (two buccal and two lingual), individual tooth mobilities and teeth to be extracted are recorded on the periodontal evaluation chart.

Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have the required pocket depths, a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

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- i) a full quadrant is considered to have four or more qualifying diseased teeth,
- ii) a partial quadrant is considered to have one, two, or three diseased teeth,
- iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Scaling and root planing are a benefit once per quadrant in a 24 month period. Patients shall exhibit a minimum of one 4mm+ pocket, connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.

(Denti-Cal Manual of Criteria- Periodontal General Policies, Section 5 effective March 1, 2008)

531-8

Endodontic therapy; root canal treatment in permanent teeth; recalcification including temporary restoration; Apicoectomy; and Apexification/Apexogenesis; are covered services, subject to prior authorization. (§51307(e)(5))

531-8A ADDED 6/08

Prior authorization with current periapical radiographs is required for initial root canal therapy, root canal retreatment, apexification/recalcification and apicoectomy/periradicular surgery on permanent teeth.

Prior authorization for root canal therapy is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.

Root canal therapy is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to nonrestorability or periodontal involvement).

Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

(Denti-Cal Manual of Criteria- Endodontic General Policies, Section 5 effective March 1, 2008)

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531-9

The statute dealing with authorizable dental benefits was amended effective August 15, 1993. Pertinent parts of that revision are set forth below:

- (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.
- (2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:
 - (A) Periodontal treatment is not a benefit.
 - (B) Endodontic therapy is not a benefit except for vital pulpotomy.
 - (C) Laboratory processed crowns are not a benefit.
 - (D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.
 - (E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.
 - (F) The department may approve services for persons with special medical disorders subject to utilization controls, including those set forth above.

(Welfare and Institutions Code §14132(h))

531-11 REVISED 6/08

The Denti-Cal Provider Manual contains the complete Manual of Criteria for Medi-Cal authorization (Dental Services). Orthodontic services for Handicapping Malocclusion are covered as follows:

The Denti-Cal Provider Manual contains the complete Manual of Criteria for Medi-Cal authorization (Dental Services). Orthodontic services for Handicapping Malocclusion are covered as follows:

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

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- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (10/05) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:
 - i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
 - v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
 - vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

(Denti-Cal Provider Manual of Criteria Orthodontic General Policies Section 5 as revised March 1, 2008) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized

- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (10/05) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:

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- i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request
- ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
- iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
- iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
- v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
- vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

(Denti-Cal Provider Manual of Criteria Orthodontic General Policies Section 5 as revised March 1, 2008)

531-11A

Requests for prior authorization for EPSDT supplemental services shall include the following information:

- (1) The principal diagnosis and significant associated diagnoses.
- (2) Prognosis.
- (3) Date of onset of the illness or condition, and etiology, if known.
- (4) Clinical significance or functional impairment caused by the illness or condition.
- (5) Specific types of services to be rendered by each discipline associated with the total treatment plan.
- (6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
- (7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.
- (8) Any other documentation available which may assist in making the required determinations.

(§51340(d))

531-11B

Orthodontic services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries are covered only when medically necessary pursuant to the criteria set forth in the

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Medi-cal "Manual of Criteria for Medi-Cal Authorization", Chapter 8.1, as incorporated by reference in §51003(e), or when medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to criteria in §51340(e)(1) or (e)(3). (§51340.1(a)(2))

531-11C REVISED 6/08

Diagnostic casts are for the evaluation of orthodontic benefits only.

Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. Casts shall be cleaned, treated with an approved EPA disinfectant and dried before being placed in a sealed bag for shipping to the Medi-Cal Dental Program. (Denti-Cal Manual of Criteria Section 5 effective March 1, 2008)

531-11G REVISED 6/08

The California Department of Health Services established regulations implementing the EPSDT program within Medi-Cal. The applicable are §§51184, 51242, 51304, 51340, 51340.1, and 51532.

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

EPSDT services are the current Denti-Cal Program's scope of benefits for beneficiaries under the age of 21.

The EPSDT program is a special process within Denti-Cal specifically for children. Under federal law, EPSDT services are provided to any Medicaid beneficiary under age 21. For the Denti-Cal Program, this means medically necessary dental services provided for any Denti-Cal beneficiary who has not yet reached his or her 21st birthday are EPSDT services.

Whenever a Medi-Cal dental provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent treatment resulting from that examination is considered to be an EPSDT dental service – *if* the dental procedure is published in the Denti-Cal Manual of Criteria.

EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program. Conversely, the dental service may be part of the Denti-Cal scope of benefits for adults but not for children; or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).

All EPSDT Supplemental Services must be prior authorized and (providers) MUST print "EPSDT Supplemental Services Request" in Field 34 of the TAR/Claim form. If the requested dental service is not listed within the Manual of Criteria, use the appropriate unspecified procedure code and fully describe the service.

At a minimum, (providers) should address the following:

- ◆ Diagnosis of the dental condition
- ◆ Any overall health issues and medical conditions

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- ◆ Prognosis with and without the requested treatment
- ◆ Clinical rationale for why a covered benefit or lower-cost service will not suffice (you are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale).

Note: Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging). In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR/Claim.

All EPSDT-SS requests for orthodontic services must include a completed Handicapping LabioLingual Deviation (HLD) Index Scoresheet in addition to the aforementioned documentation requirements. The review of active orthodontic services also requires the submission of diagnostic casts.

(Medi-Cal Dental Program Provider Handbook-Special Programs, Section 9, effective March 1, 2008)

531-11H REVISED 6/08

- a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
- b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.
- c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

(Denti-Cal Manual of Criteria Oral and Maxillofacial Surgery General Policies Section 5, effective March 1, 2008)

531-12 REVISED 6/08

As an expansion of the EPSDT program, the State has developed the Child Health and Disability Prevention (CHDP) treatment mandate, which is a program that provides health assessment screenings to Medi-Cal eligible children from birth to age 19.

The CHDP mandate states that any county receiving funds for uncompensated care "shall provide, or arrange and pay for, medically necessary follow-up treatment, including necessary follow-up dental services and prescription drugs, for any condition detected as part of a CHDP screening for a child eligible for services under the CHDP program." The legislation allows County Medical Services Program (CMSP) counties to contract back with the Department to administer their CHDP treatment mandate/obligation. The Department of Public Health administers this mandate for these counties under the Children's Treatment Program (CTP).

To qualify for CTP services, recipients must be under 19 years of age; must meet CHDP eligibility requirements; and cannot be covered by private health insurance or Medi-Cal with no share of cost, by California Children Services or any other publicly funded program. The CTP

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allows eligible recipients to be treated by Medi-Cal providers and uses Medi-Cal procedure codes, rates and scope of benefits. Every eligible child and family is informed of the importance of dental services and is offered assistance in receiving services.

(Medi-Cal Dental Provider Handbook-Special Programs Section 9, effective March 1, 2008)

531-13 ADDED 6/08

In accordance with Title 22, Section 51015, of the Title 22 California Code of Regulations (CCR), Denti-Cal has established an appeals procedure to be used by providers with complaints or grievances concerning the processing of Denti-Cal TAR/Claim forms for payment.

First Level appeals should be directed to:

Denti-Cal
Attn: Provider First Level Appeals
P.O. Box 13898
Sacramento, CA 95853-4898

(Medi-Cal Provider Manual, Section 2, Program Overview)