



# **An Advocate's Guide to Medi-Cal Services**

January 2020



**Chapter VII:  
Dental Services**

# Chapter VII: Dental Services

## Dental Services Covered in this Chapter\*

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  - General Anesthesia Services
  - Delivery System: Fee-For-Service vs. Managed Care

\*This is a non-exhaustive list of services. It may not include all available services.

While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental services are not a required benefit for adults over age 21.<sup>1</sup> Therefore, the state has flexibility in determining the scope of dental services it covers. The Medi-Cal Dental Program (Denti-Cal) covers comprehensive dental services for both children **and** adults, but the range of dental benefits covered for adults has varied significantly in recent years. In July 2009, due to budget constraints, California eliminated its comprehensive adult dental coverage. In May 2014, there was a partial restoration of Medi-Cal adult dental benefits, and on January 1, 2018, adult dental benefits were fully restored.<sup>2</sup>

## A. Adult Dental Coverage

### 1. Full-Scope Dental Benefits

Adults with full-scope Medi-Cal are eligible for comprehensive dental services.<sup>3</sup>

Adult dental services include:

- Exams and X-rays
- Cleanings (Prophylaxis)
- Fluoride Treatments
- Fillings
- Root Canals in Front Teeth
- Prefabricated Crowns (stainless steel or tooth colored)
- Full Dentures
- Denture Relines
- Other Medically Necessary Dental Services
- NEW\*: Laboratory Processed Crowns
- NEW\*: Root Canals in Back Teeth
- NEW\*: Partial Dentures
- NEW\*: Partial Denture Adjustments, Repairs, and Relines
- NEW\*: Periodontics (Scaling and Root Planing)

\*“NEW” refers to the restored benefits in 2018.

## 2. Limited Scope Dental Benefits

Adults with limited-scope Medi-Cal have restricted coverage with only extractions and emergency services covered.

Emergency services for purposes of those with limited scope coverage means:

- A condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:<sup>4</sup>
  - Placing the patient’s health in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

## 3. Dental Benefits for Pregnant Women

Pregnant Medi-Cal beneficiaries, regardless of the scope of benefits available to other adults, are eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program (as long as procedure requirements and criteria are met).<sup>5</sup> These beneficiaries are also eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th day falls.<sup>6</sup>

## 4. Cap on Adult Dental Services

Dental services for individuals 21 years or older are limited to \$1,800 per beneficiary for each calendar year.<sup>7</sup> The cap is considered a “soft” cap because once Denti-Cal has paid \$1,800 in claims; all subsequent claims require a treatment authorization request (TAR). Therefore, services can still be covered beyond \$1,800, however, documentation of medical necessity is required for approval.<sup>8</sup> The \$1,800 cap resets each calendar year.

Certain services are exempt from the cap, including:<sup>9</sup>

- Emergency dental services,
- Services that are federally mandated, including pregnancy related services,
- Dentures;
- Maxillofacial and complex oral surgery;
- Maxillofacial services, including dental implants and implant-retained prostheses; and
- Services provided in long-term facilities.

Providers may not bill beneficiaries if Medi-Cal paid **any amount** on a specific procedure.<sup>10</sup> So even if there was a partial payment, the provider must consider it payment in full.<sup>11</sup> Providers may only bill Medi-Cal beneficiaries if the beneficiary has met the \$1,800 cap, the service is not exempt from the cap, and nothing was paid on a procedure.<sup>12</sup>

## B. Children Dental Coverage

Children ages 0 to 20 with full-scope Medi-Cal benefits and are eligible for the following services:

- Oral evaluation (under age 3)
- Initial Exam (ages 3-20)
- Periodic Exam (ages 3-20)
- Prophylaxis
- Fluoride
- Restorative Services—Amalgams, Composites, and Pre-fabricated Crowns
- Laboratory Processed Crowns
- Scaling and Root planing
- Anterior Root Canals
- Posterior Root Canals
- Partial Dentures
- Full Dentures
- Extractions
- Emergency Services

Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, children under age 21 must receive benefits and services necessary to “correct or ameliorate defects and physical and mental illnesses and conditions.”<sup>13</sup> EPSDT is designed to ensure children get the health care they need when they need it, so that health problems are treated as early as possible. In addition to periodic and interperiodic assessment of the child’s teeth, EPSDT coverage must, at a minimum, include “relief of pain and infections, restoration of teeth, and maintenance of dental health.”<sup>14</sup> (For more information about EPSDT, see Chapter VIII on Children’s Health Services.)

## C. Prior authorization

Prior approval of certain dental services must be sought through a Treatment Authorization Request (TAR).<sup>15</sup> Services subject to prior authorization include restorative services, endodontics, periodontics, prosthodontics, implant services, oral and maxillofacial surgery and orthodontics services.<sup>16</sup> Services provided to patients in hospitals, skilled nursing facilities and other intermediate care facilities require prior authorization unless exempted as emergency services.<sup>17</sup> For detailed information regarding procedures requiring prior authorization, refer to “Section 5: Manual of Criteria and Schedule of Maximum Allowances” of the Medi-Cal Dental Program Provider Handbook.<sup>18</sup>

Prior authorization is not transferable from one provider to another. If for some reason the provider who received authorization is unable to complete the service or the beneficiary wishes to go to another provider, another provider cannot perform the service until a new treatment plan is authorized under the new provider’s name.

## D. Tele-dentistry

DHCS permits the use of tele-dentistry as an alternative way to provide dental services. Therefore, enrolled Denti-Cal providers may render certain services via tele-dentistry, which may be provided via “asynchronous store and forward” or “synchronous or live transmission.” Asynchronous store and forward is “the transmission of medical information to be reviewed at a later time by licensed dental provider at a distant site,” such as may occur if medical staff take images of a patient’s teeth for a dentist to review a day later.<sup>20</sup> Synchronous or live transmission “is a real-time interaction between a beneficiary and a provider located at a distant

### ADVOCACY TIP:

- ✓ The Medi-Cal Dental Program Provider Handbook contains detailed information regarding Denti-Cal policies, procedures, and instructions for completing necessary forms and other related documents. The Handbook, put together by the Department of Health Care Services (DHCS), is over 400 pages long and is updated quarterly with information from Denti-Cal Provider Bulletins. The Handbook is designed for Denti-Cal accepting providers and their staff as their primary reference for information about the Denti-Cal Program, and can also be a helpful tool for advocates.<sup>19</sup>

### ADVOCACY TIP:

- ✓ It is critical to ensure that Medi-Cal accepting dental providers bill Medi-Cal for covered dental services. This includes pursuing Medi-Cal authorization of dental treatment, including dental services for children under the EPSDT benefit.

site.”<sup>21</sup> Eligible tele-dentistry services include oral evaluation for new or established patients, periodic oral evaluation for established patients, and examination of radiographic images.

## E. General Anesthesia Services

Prior Authorization is required for general anesthesia and intravenous sedation. Only an enrolled Denti-Cal provider may request a TAR for this service. Anesthesiologists may submit a TAR if they are enrolled as a billing provider. If an anesthesiologist is not a billing provider, the billing provider rendering the dental services may submit the TAR on behalf of the anesthesiologist rendering the anesthesia. Additionally, if an anesthesiologist is part of a group practice, the group practice may submit a TAR on behalf of anesthesiologist.<sup>22</sup> Prior authorization may be waived when the service is medically necessary to treat an emergency medical condition or for beneficiaries who reside in a state certified skilled nursing facility or any category of intermediate care facility for developmentally disabled individuals.<sup>23</sup>

## F. Delivery System: FFS vs. Managed Care

Denti-Cal is administered through two delivery systems: Dental Fee-For-Service (FFS) and Dental Managed Care (DMC). Dental FFS is the delivery system in all counties except Sacramento and Los Angeles counties. DMC enrollment is mandatory in Sacramento County (with a few exceptions), and beneficiaries in Los Angeles County, have the option to enroll in a DMC.

To operationalize FFS dental services, DHCS has contracted with DXC Technology to serve as the fiscal intermediary and Delta Dental as administrative services organization. DXC processes claims and TARs submitted by dental health providers, while Delta Dental provides dental administrative services including network management.<sup>24</sup>

In the fee-for-service system, beneficiaries can access any dental provider who participates in Medi-Cal. In managed care, beneficiaries are restricted to those providers participating in the dental plan in which the beneficiary is enrolled.<sup>25</sup>

### Resources:

- Denti-Cal Provider Handbook: [https://www.denti-cal.ca.gov/DC\\_documents/providers/provider\\_handbook/handbook.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf)
- Denti-Cal Beneficiary Handbook: [https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Beneficiary\\_Handbook/](https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Beneficiary_Handbook/)
- Dental Credit Card Debt: California Advocates Toolkit: <https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/>

# Endnotes

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<sup>1</sup> 42 U.S.C. § 1396d(a)(10).

<sup>2</sup> See CAL. WELF. & INST. CODE § 14131.10(b)(2)(C) for the May 2014 restoration, and CAL. WELF. & INST. CODE § 14131.10(b)(1)(A)(i) for the 2018 restoration. See also Cal. Dep't Health Care Servs., All Plan Letter 17-009 (Nov. 27, 2017) (informing Medi-Cal Dental Managed Care Plans of the full restoration of adult dental benefits), [https://www.dhcs.ca.gov/services/Documents/MDSD/2017%20DAPLs/APL\\_17-009\\_Fully\\_Restore\\_Adult\\_Dental\\_Benefits.pdf](https://www.dhcs.ca.gov/services/Documents/MDSD/2017%20DAPLs/APL_17-009_Fully_Restore_Adult_Dental_Benefits.pdf), and Cal. Dep't Health Care Servs., *Full Restoration of Adult Dental Benefits – Frequently asked questions* (Jan. 1, 2018), [https://www.dhcs.ca.gov/services/Documents/MDSD/Adult\\_Resto\\_FAQ-Fact\\_Sheet\\_12-2017.pdf](https://www.dhcs.ca.gov/services/Documents/MDSD/Adult_Resto_FAQ-Fact_Sheet_12-2017.pdf).

<sup>3</sup> *Id.*

<sup>4</sup> CAL. WELF. & INST. CODE § 14007.5(d).

<sup>5</sup> Cal. Dep't Health Care Servs., *Medi-Cal Dental Program Provider Handbook* 4-12 (Dec. 2019) [hereinafter Denti-Cal Provider Handbook], [https://www.denti-cal.ca.gov/DC\\_documents/providers/provider\\_handbook/handbook.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf).

<sup>6</sup> CAL. WELF. & INST. CODE § 14005.18(a).

<sup>7</sup> CAL. WELF. & INST. CODE § 14080(a).

<sup>8</sup> Denti-Cal Provider Handbook, *supra* note 5, at 4-11 and 4-12.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> 42 U.S.C. § 1396d(r)(5). See also Cal. Health & Safety Code § 124025 et seq., CAL. WELF. & INST. CODE § 14132(v), CAL. CODE REGS. tit. 22 §§ 51184, 51242, 51340, 51340.1, 51532.

<sup>14</sup> 42 C.F.R. § 441.56(c)(2); CAL. CODE REGS. tit. 17, § 6843(a)(1).

<sup>15</sup> Denti-Cal Provider Handbook, *supra* note 5, at 2-11.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* see also CAL. CODE REGS. tit. 22, § 51056 (a), (b).

<sup>18</sup> Denti-Cal Provider Handbook, *supra* note 5, at 5-1 to 5-126.

<sup>19</sup> See Michelle Lillienfeld, Nat'l Health Law Prog., *Dental Credit Card Debt: California Advocates Toolkit* (Dec. 2018) (Appendix 2 of Dental Credit Card Toolkit provides a reference sheet to help advocates get acquainted with the services section of the Denti-Cal Provider Handbook), <https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/>.

- <sup>20</sup> Cal. Dep't Health Care Servs., *Denti-Cal Bulletin* Vol. 32, 4 (Mar. 2016), [https://www.denti-cal.ca.gov/DC\\_documents/providers/provider\\_bulletins/archive/Volume\\_32\\_Number\\_04.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/archive/Volume_32_Number_04.pdf).
- <sup>21</sup> Each transmission is "limited to 90 minutes per beneficiary per provider, per day." *Id.*
- <sup>22</sup> For helpful flow charts to help determine whether or not a beneficiary is eligible for such services, see Cal. Dep't Health Care Servs., Dental All Plan Letter 17-004 (Jun. 28, 2017), [http://www.dhcs.ca.gov/services/Documents/MDS2017%20DAPLs/APL17\\_004.pdf](http://www.dhcs.ca.gov/services/Documents/MDS2017%20DAPLs/APL17_004.pdf).
- <sup>23</sup> Cal. Dep't Health Care Servs., Dental All Plan Letter 15-005, at 2 (Apr. 1, 2015), <https://www.dhcs.ca.gov/services/Documents/MDS2015%20DAPLs/APL%2015-005.pdf>.
- <sup>24</sup> Cal. Dep't Health Care Servs., *Denti-Cal Bulletin* Vol. 33, 11 (Sept. 2017), [https://www.denti-cal.ca.gov/DC\\_documents/providers/provider\\_bulletins/Volume\\_33\\_Number\\_11.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_33_Number_11.pdf).
- <sup>25</sup> CAL. WELF. & INST. CODE § 14087.46; Cal. Dep't Health Care Servs., All County Welfare Directors' Letter 94-88 (Nov. 21, 1994), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c94-88.pdf>.