

# Accessing Dental Care Through the Denti-Cal Program

The **primary objective** of the Denti-Cal Program is to create a better dental care system and increase quality of services available to those individuals and families who rely on Medi-Cal to meet their health care needs.<sup>1</sup>

## **Administration:**

Denti-Cal is the dental care segment of the Medi-Cal program.

Denti-Cal is administered by a private managed care plan, Delta Dental. Delta Dental's primary function is to process claims and treatment authorization request (TARs) submitted by providers for dental services performed for Medi-Cal beneficiaries. The most recent contract between California Department of Health Services (DHS) and Delta Dental was signed in 1998. The contract runs for four years, with two possible one-year extensions.

Eligibility, administration and scope of services is governed by Welfare and Institutions Code § 14000 *et seq.* and Title 10 and Title 22 of the California Code of Regulations. Additional guidance about the program is provided in the Denti-Cal Provider Manual.<sup>2</sup>

## **Eligibility:**

Individuals who are enrolled in the Medi-Cal Program are eligible to receive dental services provided by Denti-Cal. Eligibility is verified through presentation of a Beneficiary Identification Card, known as a BIC card. Certain limitations in access to dental services may apply to the following beneficiaries: 1) individuals enrolled in prepaid health plan which provides dental services, 2) individuals enrolled in another pilot program which provides dental services; 3) individuals who are assigned special aid codes; 4) individuals with minor consent restricted cards.<sup>3</sup>

Upon verifying eligibility in Medi-Cal, a provider cannot bill the beneficiary for any part of the charge for a Medi-Cal covered service, except to collect copayments<sup>4</sup> or share of cost. Providers can request payment of share of cost. Additionally, providers can input information about incurred medical expenses into the AEVS system (Automated Eligibility Verification System), which can help a beneficiary satisfy her share of cost obligation.

## **Services:**

Generally, Denti-Cal covers inpatient and outpatient dental services "which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury or defect."<sup>5</sup> A number of dental services, including emergency and diagnostic services, including examinations, radiographs, biopsies and dental prophylaxis, are covered without prior authorization.<sup>6</sup>

Denti-Cal services are provided through fee-for-service as well as managed care arrangements. In the fee-for-service system, beneficiaries can access any dental provider who participates in Medi-Cal in their geographic area. In managed care, beneficiaries are restricted to those

providers participating in the dental plan. Additionally, in the fee-for-service system, approval of some services must be sought through a Treatment Authorization Request (TAR).<sup>7</sup> In managed care, approval of certain services is provided by the health plan through its pre-authorization process.

A TAR consists of one or more documents completed and submitted by dentists or other providers to request Denti-Cal approval of performance of certain services. In these documents, providers attest to the fact that the service is medically necessary for the beneficiary. Delta Dental receives and reviews the TAR. If the TAR meets all requirements, a notice of authorization form is sent, explaining that the service has been approved. If information submitted for the claim or TAR is insufficient, the document is held for further manual review and in some cases, additional information is requested. Medi-Cal law mandates that TAR decisions must be made within an average of five working days after DHS receives the TAR.<sup>8</sup> However, DHS's contract with Delta Dental allows the managed care plan fifteen days to make decisions. If a decision on a TAR is not made within 30 days of receipt of the request, the TAR is deemed approved.

Some services, such as cosmetic procedures, experimental procedures and procedures that increase vertical dimension or restore occlusion, are excluded from coverage by Denti-Cal.<sup>9</sup>

#### **Early and Periodic Screening Diagnosis and Treatment Program:**

Children needing dental services not covered for adults can obtain such services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Part of federal Medicaid requirements, EPSDT mandates that children enrolled in Medicaid have access to medically necessary services. Medical necessary services are defined broadly as those services needed "to correct or ameliorate" conditions or illnesses of children under the age of 21.<sup>10</sup> For children's oral health, the EPSDT standard requires that care be provided for "relief of pain and infections, restoration of teeth and maintenance of dental health."<sup>11</sup> This means that children enrolled in Medi-Cal can obtain those dental services not covered for adults, including orthodontia<sup>12</sup>, fixed bridgework and partial dentures. When dental providers treating children seek TAR approval for coverage of benefits not offered to adults, they must indicate that the child's condition meets the EPSDT medical necessity standards.

#### **Other Coverage:**

Because Medi-Cal is the payer of last resort, payment must be sought from all other carriers in cases where a beneficiary has other health care coverage.<sup>13</sup> Where the primary payer pays less than the maximum Denti-Cal allowance, Denti-Cal will pay up to the maximum allowance for Denti-Cal covered benefits.<sup>14</sup>

#### **Appeals Process**

If Denti-Cal denies coverage of a dental service to which a beneficiary believes she is entitled, she can appeal the denial, just as she would in Medi-Cal. Beneficiaries can challenge denials by requesting a fair hearing within ninety days from the date of the notice of action denying services.<sup>15</sup> They can request a fair hearing by completing and faxing or mailing the reverse side of the Denti-Cal notice of action or calling (800) 743-8525. If the beneficiary no longer had the notice of action or never received one, she can mail a letter to the Office of the Chief

Administrative Law Judge.<sup>16</sup> The letter should include the beneficiary's name, Medi-Cal number or Social Security number, address and phone number as well as a general statement about why the beneficiary is requesting a fair hearing. Beneficiaries who are enrolled in dental health plans have the option of requesting a fair hearing or filing a grievance, or doing both.<sup>17</sup>

## ENDNOTES

1. Denti-Cal Provider Manual, DHS, Program Objectives, pg. 1-1.
2. Note, however, that the Denti-Cal Provider Manual's interpretation of covered benefits is more restrictive than what is legally allowed. *See Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program*, Health Consumer Alliance, pg. 16 (2002).
3. Denti-Cal Provider Manual, DHS, Beneficiary Eligibility, pg. 2-19.
4. For a schedule of copayments for dental services, *see* CAL. CODE REGS. tit. 10 § 2699.6211.
5. CAL. CODE REGS. tit. 22 § 51307(a). Note that in providing dental services, Denti-Cal providers are obligated, as federal fund recipients, to offer language assistance services pursuant to Title VI. *See* 42 U.S.C. § 2000d and 67 Fed. Reg. 4968 (Feb. 1, 2002)(OCR Limited English Proficiency Guidance).
6. CAL. CODE REGS. tit. 22 § 51307(b). Other covered services which do not require prior authorization include dental extractions, injectable therapeutic drugs, occlusal adjustment, gingivectomy or gingivoplasty per quadrant, vital pulpotomy, treatment of dental caries, cast or performed posts, endothermic reline, space maintainers, repairs for existing crowns, bridges and removable dentures, and reduction of oral and maxillofacial fractures and dislocations. For details about coverage of these procedures, please see the regulations cited above. Note that Governor Davis recently approved the decrease in Denti-Cal screenings for adults from once every six months to once every twelve months.  

See also CAL. WELF. & INST. CODE § 14132(h)(1). According to this section, "[e]mergency 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 which are lost or destroyed due to circumstances beyond the beneficiary's control."
7. According to the Denti-Cal Provider Manual, "It is the intent of Denti-Cal to process claims and TARs as quickly and efficiently as possible." Denti-Cal Provider Manual, DHS, Overview of Claim and Treatment Authorization Request (TAR) Processing, pg. 1-1.
8. *See* CAL. WELF. & INST. CODE §§ 14103.6, 14133.9(d).
9. CAL. CODE REGS. tit. 22 § 51307(d). Additionally, the following services are not covered: orthodontic services, except for handicapping malocclusion and cleft palate deformities, treatment of incipient or nonactive caries in adults, removable partial dental prostheses, extraction of asymptomatic teeth, pulp caps, and fixed bridges, except when necessary for obtaining employment or medical conditions which preclude use of removable dental prostheses.
10. *See* 42 U.S.C. §§ 1396a(a)(10)(a), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). *See also* CAL WELF. & INST. CODE §§ 124025 *et seq.*, 14132(v).

11. 42 C.F.R. § 441.56(c)(2).
12. Denti-Cal coverage of orthodontia is complicated and confusing. DHS uses the modified Handicapping Labio-Lingual Deviation (HLD) Index to determine whether orthodontics will be covered for children with handicapping malocclusions. While DHS requires a score of 26 or higher on the HLD index in order to qualify for the treatment, children with scores below 26 points should be able to obtain orthodontic treatment if they meet the EPSDT standard. *See* Denti-Cal Provider Manual, DHS, Orthodontic Services for Handicapping Malocclusion and Early and Periodic Screening, Diagnosis and Treatment (EPSDT), p. 4-45 - 4-46.
13. CAL. WELF. & INST. CODE § 14124.90.
14. Denti-Cal Provider Manual, DHS, Other Coverage, pg. 2-46.
15. CAL. WELF. & INST. CODE § 10951.
16. Letters should be mailed to Office of the Chief Administrative Law Judge, State Hearings Division, Department of Social Services, 744 P Street, Mail Stop 37-19, Sacramento, California 95814.
17. If beneficiaries pursue a grievance, they should be aware of the fact that the 90 day window to request a fair hearing is not tolled. For that reason, advocates are encouraged to file a grievance and fair hearing simultaneously. In some instances, filing a fair hearing may encourage the plan to resolve the dispute. If the beneficiary receives a favorable outcome on the grievance, she may withdraw her fair hearing request.